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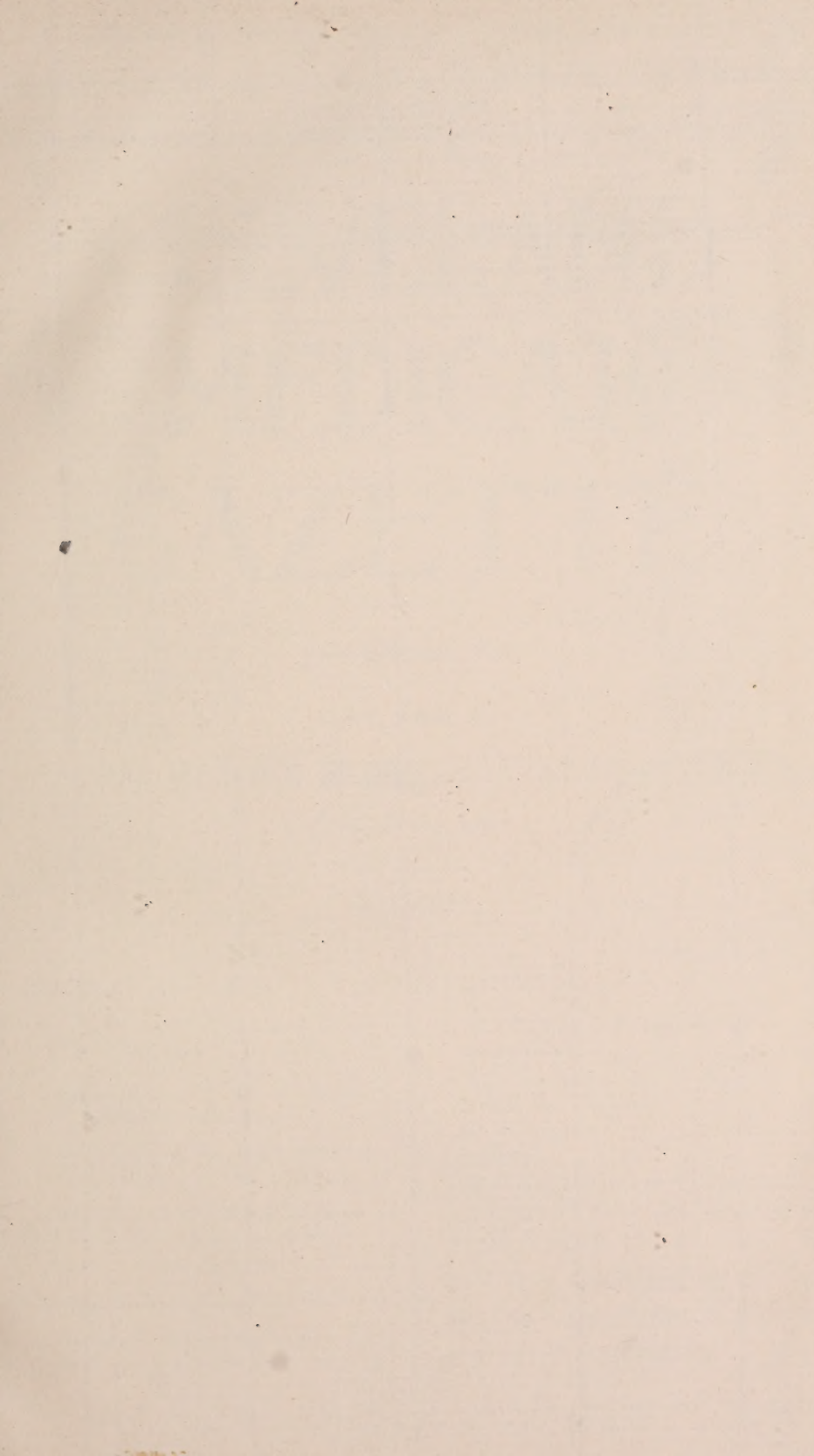






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# THE CLEVELAND MEDICAL GAZETTE

Vol. XV.

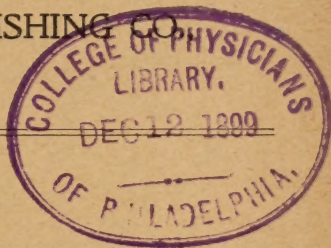
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*Medical Letters may be addressed to*

**Mr. FELLOWS, 48 Vesey Street, NEW YORK.**



# THE Cleveland Medical Gazette

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NOVEMBER, 1899.

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## Original Articles.

### THE STUDY OF VISCERAL ANATOMY.

BY BYRON ROBINSON, B. S., M. D., OF CHICAGO.

Prof. in Chicago Post Graduate School of Gynecology and Abdominal Surgery, Prof. of Gynecology in Illinois Medical College and Harvey Medical College.

*(Written for the Cleveland Medical Gazette.)*

The anatomy of the abdominal viscera is one of the most important subjects in a college course. A dozen years ago I began the special study and teaching of the visceral anatomy. At first only a few progressive persons would spend the time to listen to the demonstrations. I suggested courses in visceral anatomy to the leading colleges in Chicago, but the authorities only smiled at the absurdity and said it is simply foolish to divide the chair of anatomy. Ten years ago I began with regular courses of applied and descriptive anatomy of the abdomen, always having at the lecture the abdominal viscera of a human or dog. A genuine professor of merit once asked me how it was possible to give twenty lectures on the descriptive and applied anatomy of the abdominal viscera and not repeat. Said he, where do you get enough ideas to last for twenty hours? The first five years the number of doctors in the class was limited. Since 1895 the subject of visceral anatomy has increased in importance until nearly every college in Chicago at least pretends to have a course on descriptive and applied anatomy of the abdomen.

However, it is a long neglected subject. Especially is it demanded that the study of visceral anatomy should be long and thorough just now, when the "new school of abdominal special-

ists" passes from graduation day into practice "limited to abdominal surgery." The pendulum is swinging very hard, aided frequently by the demoralizing special private hospital, which induces autocratic and avaricious methods with the physician and hero worship with the patient. We never needed such thorough study of visceral anatomy as we do now, because of the widespread amateur practice in abdominal surgery.

For years I have advocated the view that every medical college should establish a chair of visceral anatomy. The reader may ask why visceral anatomy has claims for a separate chair. Does not the anatomist teach all anatomy? If special or regional anatomy is further required, does not each chair give ample description of the department under its charge? I answer both questions positively with an accentuated NO. The most needed and most useful of all anatomy for the practitioner is visceral anatomy. But it is the most slighted of all exact anatomical teaching.

Have I new methods to offer for the study of anatomy? No; but I would make the study of practical anatomy extend over the whole course. The first year work on anatomy should be limited to dissecting animals. Each student should repeatedly dissect every part. The most convenient method would be to employ the dog, embryonic pigs, sheep and calves from the slaughter-house.

What does one mean by visceral anatomy? It means, in a general sense the anatomy of the nervous system and of the organs contained in the abdominal and thoracic cavities. My experience in the dissection of both nerves and viscera of the dog, pig, sheep and calf are that the comparisons with the human are reliable, useful and highly practical. I would especially note that the sympathetic nerve system is almost exactly identical in distribution and function in both man and animals.

The chair which the writer would advocate in every medical college is for the purpose of instruction in descriptive and applied anatomy of the contents of the chest and abdomen. Visceral anatomy is the most difficult of all anatomy.

First. Because nearly all the organs are quite mobile without becoming dislocated. No organ is without movement.

Second. The organs have the capacity of altering their size and form without destroying their integrity or ability to return to the normal condition. The colon will expand as large as a stove-pipe and return to a normal state on removal of the exciting cause. The most notable case is the uterus for its changing condition,



though the liver and lungs are continually altering their condition.

Third. Many of the organs have wonderful elasticity. They have typical expansion and contraction, not from muscle merely, but from the endowment of elastic fibers in the organ themselves, and in their connection and anchorage.

Fourth. The difficulty of visceral anatomy is enhanced by the different kinds and duration of rhythm, belonging to each viscus. Every organ has its own rhythm, or form of peristaltic movement. The heart and lungs each have their own kind of rhythm. The duration of the rhythm of each organ varies, but holds a fairly definite relation with each other, as, e. g., one to four. The liver goes through its own peculiar rhythm in the formation of bile, glycogen and urea. The monthly motion of the oviducts and uterus is a good example. The organs of the chest are fixed in position and definite in duration of rhythm, which with a few organs enables a more accurate diagnosis to be made. In the abdomen no two organs are alike in rhythm, and the numerous organs without fixed position makes definite diagnosis very uncertain. Every student should be taught first principles.

Fifth. The difficulty of diagnosis on the abdomen is enhanced by the fact that the position of some of the organs are very variable. By elongation or shifting of visceral supports the spleen may be on the pelvic floor, the kidney and liver wander from their accustomed locations. The stomach may rest on the pelvic floor and the sigmoid loop may lie anywhere in the abdominal cavity. The changing position of the appendix and coecum is one of the most significant factors both to the surgeon and the patient's safety. For example, the coecum (and appendix) may be found at any point on a line extending from the under border of the liver along the psoas to the pelvic floor, and should the appendix rupture along this line it is comparatively safe, for it is the benign area of colonic peritonitis. Again the coecum (and appendix) may possess a long peritoneal support and take the position of least resistance which is in the middle of the abdomen and among the enteronic loops, the dangerous area of enteronic peritonitis. This position of viscera often throws the dice of life and death decisions.

The dissecting could be done on fresh animals with or without injections. The dissecting room should be respectable to live in. Disgusting odors dampen enthusiasm, and there is no excuse for ill-smelling rooms now when by little effort and a slight expense we can inject bodies which will remain odorless for months.



I have worked over a body for three months with scarcely any odor.

Who should instruct in the chair of visceral anatomy? He should be one who practices abdominal surgery. He should not only know the physiology and the anatomy of the viscera, but he should be an expert in the applied anatomy, i. e., in the interpretation of pathological phenomena. The teacher who aspires to impart knowledge of the viscera should have thoroughly mastered especially the anatomy of the cerebro-spinal axis. He should be well versed in general anatomy before he attempts to teach special anatomy. He should be, in short, a very practical teacher. He should learn to instruct as practically as Mr. Treves can write. The applied anatomy of the viscera is really applied knowledge of the great sympathetic nerve. The viscera and the sympathetic nerve are one and inseparable in applied anatomy.

The physician who teaches visceral anatomy should be master of the field from peritoneal dissection, from clinical and surgical experience and study of pathology. No person can comprehend human visceral anatomy without a practical study and dissection in both embryology and comparative anatomy. Practical teaching in visceral anatomy requires that the teacher knows the landmarks which are points of consideration, anatomic, physiologic and pathologic. The primordial segments of the tractus intestinalis must be dissected from fish to man in order to understand their anatomy and physiology. The digestive tract is divided by fixed, or constant, sphincters and flexures, and the chief pathology is found in those great landmarks. A sphincter possesses (a) a delicate nerve supply; (b) a large lymphatic supply; (c) a high blood supply, and (d) an aggregation of circular muscles. A sphincter is a guard to an orifice and is subject to frequent and rapid congestions and decongestations. It has a high physiologic activity and is subject to malignancy and stricture, perhaps, from trauma and infection. Sphincters are very ancient landmarks of the digestive tract. Flexures have little physiology but are landmarks in anatomy and pathology. The flexure is subject to strictures and malignancy from trauma and infection. Hardened faeces, containing sharp bodies, abrade the mucosa, as they pass, by the flexure establishing an atrium of infection, whence infection passes through the tunica mucosa, tunica muscularis, and finally into the tunica serosa.

Treves' "Applied Anatomy" and Cunningham's "Short Anatomical Work" should be at the student's hand, and I must say

that qualified demonstrators of viscera should be much more on hand than at present. The student ought to make drawings of visceral relations. He should be impressed with visceral landmarks. It requires time to learn topographical anatomy. All the dissecting should be personal and practical. The student must learn to do and feel with his fingers and see with his eyes.

In teaching anatomy to students at medical colleges, I believe I have been justified in really neglecting most of the dry bones and quiet muscles, so that the time of the students could be spent on the nervous system and viscera. The sympathetic nerve is very difficult to master. It is very widespread, and its function is in proportion to its extent of distribution.

The sympathetic nerve must be studied by dissection if the reflexes of the body are ever to be comprehended.

Of the great medical tripod—*anatomy, physiology and pathology*—anatomy is the most essential and important, for neither physiology nor pathology can be intelligible without structure. The vast plexuses and ganglia of the sympathetic nerve must be carefully studied anatomically, in order to produce reason for diagnosis.

The neglect of the great sympathetic nerve is not justified by the neurologist, and the general practitioner and surgeon knows but little about its utility.

The reflexion and distribution of forces by means of the sympathetic nerve and its ganglia are important matters to physicians. But what general anatomist imparts intelligent instruction to them? How many general anatomists are able to explain to students why a single pus collection will paralyze the whole digestive tract below the diaphragm, while general suppurative peritonitis may not paralyze a foot of gut? The whole matter is explained by reflex action passing over definite anatomical lines and reorganized in definite ganglia. It is a notorious fact that surgeons study anatomy more than physicians, for the simple reason that anatomies are written more especially for surgeons. The anatomy fits the surgeon's case. But the poor physician must make his own applied anatomy, for few are especially written for him.

Anatomy is a personal matter and is a lifelong need, for all diagnosis must rest on change of structure in order to have changed function. If more applied anatomy, such as Treves writes, could be spread among doctors, greater blessing would follow the patient. Let one, for example, attempt to find one good, thorough, interesting applied anatomy of the female genital organs and he will tire out before he finds it.



And no organs in the whole body are abused like the female genitals, but I am sure it is more ignorance than knavery.

Gynecology in its practical application to daily use is not sufficiently taught. For example, I made a considerable inquiry among the leading colleges of Chicago by asking the recent graduates how many gynecologic examinations they had made during their entire course. I was astonished to find that the average number was only six gynecologic examinations. Can it be possible that a student who has made a half dozen bimanual examinations is able to diagnose and treat diseases of women? Is it a wonder that he mistakes normal for pathologic organs and becomes a "belly ripper" for healthy ovaries which are the very organs a woman should not lose. When a student understands viscera he will respect them. The great Lawson Tait began at the wrong end of the genital tract. He removed ovaries and oviducts. I was the student of that mighty genius ten years ago. Five years ago I began to reverse Tait's practice by removing the uterus and leaving the ovary and oviducts. The ovary is the essential and all important sexual organ of woman and should not be removed except under rare conditions. It is the appendage of the ovary, the uterus, which should be sacrificed. If the oviducts, broad ligaments and ovaries are left intact, precipitate menopause will rarely occur. The simple vaginal removal of the uterus is safe, leaves other essential genitals intact, stops menstruation or function and does not unsex the woman.

The student should be taught practically all these fundamentals by practical specialists, especially in the viscera.

The student should pursue applied visceral anatomy during the whole course to be allotted a certain amount of work to do. Visceral anatomy is especially needed now during the craze for laparotomy, so that murder may not be quite so apparent. I have quizzed scores of doctors of years practice who could not actually tell me the anatomic difference between the large and small intestine.

The chair of visceral anatomy should be filled by one not only familiar with applied anatomy (practice), but he should be experienced in pathology of viscera. He should have witnessed and performed many post-mortems. He should be so practical that no student would be allowed to graduate without many times showing his ability to handle and demonstrate intelligently every viscus. The relations of the viscera are difficult to comprehend

and require repeated explanations as regards development and adult structure.

To understand human visceral anatomy all the threads of evolutionary development can be caught up by dissecting animals. Visceral anatomy should be taught only from the cadaver, or very exceptionally some points may be taught while performing abdominal section. The dead body should be used with exposed viscera at every lecture. The only physicians who will acknowledge that visceral anatomy is very difficult are those who have tried to master it. It requires about five years to well understand and know how to teach visceral anatomy. The viscera of the animals below man must be carefully handled and studied in order to understand those of man. The thread of development must be caught up to comprehend the slow changes along the scale of animal life. The vestigial remains of man, as the appendix, the branchial clefts and the parovarium, must be studied through ages of development, as the animals show in the various stages of embryonal periods.

The diseases found in animal viscera will enlighten the student on those found in man's. The student must be taught the weak points of the viscera, which means the points where disease arises. This will aid him in making diagnosis. For example, the digestive tract has two physiological and two sphincters—the pylorus and ileo-cecal valve—and one mechanical sphincter—the anus. In such points diseases will arise as carcinoma. Pathology arises in those sphincters on account of variation of blood and lymph supply and activity of muscle. The digestive tract has other weak points, as the hepatic and spleen flexures and the sigmoid flexure. Pathology frequently arises in these six points of the tract, and the instructor must teach the student how to find the points and when to suspect them in a diseased condition.

Not only should the student pursue visceral anatomy in some method during its course, but those students who expected to do surgical work should be selected during their senior years and taught experimental abdominal surgery in small classes.

Every student intending to practice surgery should perform with his own hands operations on animal viscera and afterwards such students should kill the animal and perform his own autopsy to observe the results of his experiment. Senior students should be taught how to perform animal experiments by a competent man.

To show how difficult visceral anatomy is, one needs only to note the fight over the position of the uterus for fifty years. Ex-



perienced eyes and hands disagree as to what holds the uterus in position. "Gray's Anatomy," edition for 1893, asserts that the uterus is retained in position by the broad ligaments. It does not even mention that the sacro-uterine ligaments and vagina are the real retainers of the uterus. Any one who repeatedly dissects female bodies with care will know that the broad ligament and round ligament are not so important as the uterine retractors or as the sacro-uterine. But Gray of 1893, the accumulated knowledge of ages, omits such essential factors. Then, if so-called anatomists quarrel as to the real uterine supports, how deficient must be the general practitioner's knowledge of the viscera, who has done but little dissection in his entire life. If the visceral pathology was so difficult that for thousands of years men disputed whether we had cellulitis or peritonitis, it only shows that such matters should be better taught. A knowledge of visceral anatomy is the basis of a diagnosis. Every symptom is an indication of pathology. One familiar with the anatomical line, indicating where irritation can be carried, comprehends causes and effects. Pain can only be caused by nerves.

Reflexes must give some distinct irritation. Applied anatomy of the viscera enables one to find the cause of the irritation and remedy its effects.

The student must be taught how to observe the relation of cause and effect. He should have pointed out to him the essential landmarks of visceral disease. He ought to know that probability is the rule of life and e. g., in peritonitis he should be told that it is liable to arise in one of the three great peritonitis districts, viz.: pelvic, appendicular, or gall-bladder region. The chief organs which cause distant reflexes in other organs are the genitals. Time and time again I have demonstrated to doctors the error of treating stomach complaints when the genital organs (male and female) could be found in a pathologic condition. Reflexes go on unconsciously, and the patient only perceives the effect or result. The vomiting of pregnancy and other visceral irritations have a rational basis as soon as one thoroughly learns it—plexuses of the sympathetic nerve. Headaches will often disappear like magic by removal of genital irritation.

The anatomical idea is the kernel of modern medicine. Disease begins at distinct points in distinct structures. Knowledge of visceral anatomy will enable the physician to locate pathological focus. A good anatomist makes the safe surgeon and the wise physician. As a gynecologist I meet continually eye-troubles, sec-

ondary and dependent on disease of the genitals. Three months ago, a boy of 18 was sent to me by a physician for "fits." He had one to five fits daily. Some of the celebrated oculists of the city treated him for eye difficulty. One oculist, who paid some attention to reflexes, said it appeared that the trouble lay outside the eye. I examined his genitals and found the glans penis covered over with adhesions and a solid coating of glandular secretions. This was ordered to be carefully washed and kept clean. He had but two or three fits in the following six months. His eyes are better. Here is a good example of what reflexes will do. He has gained some fifteen pounds.

My experience in teaching gynecology, and abdominal surgery, to general practitioners, in post-graduate schools, has been the most impressive in finding a lack of anatomical knowledge. Besides I received little or no instruction in visceral anatomy in my own medical course. I never so keenly experienced the lack of any medical knowledge as I did that of visceral anatomy. Soon after leaving college I began learning it from animals, especially the dog and cow.

The knowledge of the viscera in company with the sympathetic nerve will enable one to comprehend the "reflexes." For example, diseased genital organs will induce indigestion, malnutrition, anaemia and neurosis—all by the irritation being carried to the abdominal brain, where it is reorganized and then sent out to all the viscera; such reflexes will induce excessive, deficient or disproportionate secretions in the digestive tract, liver, genitals and kidney. A distant reflex will unbalance the rhythm of all the viscera.

A knowledge of the visceral anatomy will be the best check on unnecessary amateur surgery. I verily believe that many young, amateur surgeons actually do laparotomy from pure ignorance. If they knew the complications they would not attempt the operation.

Only the past month a physician of eight years' practice came to me to learn gynecology and abdominal surgery. He said he wanted to learn the surgical part. To my surprise I could not get him to examine women in the gynecologic clinic as he said he had no use for common cases, he wanted cases with big tumors only.

He actually could not locate the position of the uterus, yet he said that it was absolutely necessary for him to learn to "cut" as the whole county referred their surgery to him. He was troubled with ignorance of comprehension, admitting that the small, un-



equipped school which graduated him taught him no visceral anatomy or gynecology.

A knowledge of visceral anatomy, with its intimate sympathetic nervous connection, will alone enable the physician to make rational diagnosis. It enables the cause to be detected from the results or effects. A more widespread knowledge of visceral anatomy will check the wholesale so-called laparotomy for "cystic" ovaries. It will show all physicians that the ovary is naturally a cystic organ, and varies in size as the breasts do; that it is the essential sexual organ of women and should be retained. If any part of the genital be sacrificed, let it be the appendages of the ovary, which are the uterus and oviducts.

Anatomical knowledge is the basis of medicine and rational diagnosis. Visceral anatomy should be popularized so that the normal appendix will not be in danger of too frequent removal. A little knowledge is a dangerous thing, especially if it be very little, and nowhere is small anatomical knowledge so dangerous as in the abdominal cavity. Visceral anatomy is the basis of study in watching the progress of pathological conditions. A familiarity with the sympathetic nerve and ganglia is absolutely necessary for the interpretation of the signs and symptoms of disease of the viscera. Visceral anatomy is the basis of all rational therapeutics. If one understands reflexes, referred pain, and visceral symptoms in the disease, he will at once know where to point his remedy. He will then be following cause and effect to their sources.

The teaching of visceral anatomy has been neglected. It is neglected and slighted in veterinary schools. A short time ago I requested to be allowed to study the viscera among a number of horses slaughtered for veterinary students to dissect. I was two hours late, and about all I saw of that batch of solid viscera was contained in barrels standing by the eviscerated carcasses. These students were merely studying dry bone, muscle, and artery, for which they would have limited use after graduation. The very soul of practice is the viscera and nervous system.

A knowledge of visceral anatomy will explain how an irritation in any viscus can unbalance the rhythm of all the viscera. It will show how the irritation may cause hypertrophy and fatty degeneration of the heart and liver by disturbing the rhythm and nutrition of these organs. It will teach physicians that, in young adults, stomach complaints and most visceral derangements are of genital origin, and due to reflexes. It will clear up many cases of so-called hysteria and clearly show that it was due to an irrita-

tion in some viscus. But in order to learn visceral anatomy so that it will be of practical use, one must handle the viscera. He must see them and feel them with his own hands.

## CONCLUSIONS.

1. Every college should have a chair of descriptive and applied visceral anatomy.
2. It should continue through the whole course of four years.
3. It should be taught by a practical abdominal surgeon.
4. Animal viscera should be employed the first year.
5. The chair should instruct every senior how to perform experiments on the viscera of animals, and each student should perform a certain number himself, killing the animal and performing the autopsy.
6. Such instructions will lessen the amateur and unnecessary abdominal surgery and the slaughter of the genitals which is so prevalent.

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REPORT AND DISCUSSION OF A CASE.\*

BY DR. HOWARD S. STRAIGHT, OF CLEVELAND.

June 21, 1898, a young man, aged 25 years, was referred to me because of a catarrh in the head. His history was negative. His complaint was only of a nasal catarrh. He was apparently a strong, healthy fellow, and subsequent physical examination showed no disease of lungs, heart, liver or kidneys. His hearing was normal. He had also no laryngeal disease.

The diagnosis at the first visit, as far as made, was hypertrophic rhinitis, unatrophied adenoids, well-marked enlargement of the tonsils, and a long, longitudinal, obstructing ridge in the respiratory area on the left side of the septum. To this list should have been added mucous polypi and an empyema of each maxillary and each frontal sinus.

The adenoids were removed, the tonsils excised, the ridge on the septum was sawed off, and a cauterization of the right lower turbinated body was made. Within two weeks after he came under my observation, the polypi were discovered, and removal begun.

An exploratory puncture of the right maxillary sinus was made, and upon washing out the sinus a liberal quantity of pus

\* Read before the union meeting of the North Eastern Ohio, East Ohio, and Union Medical Societies, held at Alliance, Ohio, Oct. 17, 1899.



was found. Under laughing gas a tooth was extracted and an opening made into the most dependant part of the sinus. Within ten days an exploratory puncture was made into the left maxillary sinus. The condition found was the same as in the right maxillary sinus, and the treatment was the same. The patient was taught to wash out the sinuses twice a day.

The amount of pus in the nose diminished, the patient was greatly improved in every way, and the case seemed to be progressing to a satisfactory conclusion. He had now been under observation about seven weeks. Without my knowledge or consent he abandoned his position—that of receiving teller in a bank—and went home, seventy-five miles from Cleveland. I saw no more of him until March 16, 1899. He had continued to wash out the maxillary sinuses twice a day. The discharge had not, however, specially lessened in quantity within the last few months. In the office he washed out each maxillary sinus. Then I knew that if pus should reappear in the nose within a few minutes of the time of washing, some other source than the maxillary sinuses must be responsible for the presence of pus.

Inspection of the nose showed in a short time a slight re-accumulation of pus; when wiped away it would re-accumulate within a few moments. This was true of each side of the nose. I then diagnosed positively what I always suspect but rarely find in connection with maxillary sinus disease, i. e., an empyema of each frontal sinus. The external operation was advised, but the patient disappeared again until May 18, 1899. The examination at this time simply confirmed the opinion as already given, and an operation was urged as his only hope of relief.

Under ether, in the hospital May 24, 1899, the external operation was made upon each frontal sinus. Use was made of every possible aseptic precaution.

The patient feared this operation greatly, as he had feared all previous ones. He was extremely nervous and took ether badly. His reaction under laughing gas had been the same on two previous occasions. I had learned that he was a bad subject for operative procedure, and was more than ordinarily alive to the danger involved. Whether his physical make-up did not have much to do with the unfortunate outcome of the case will always be a question in my mind.

An opening about the size of a dime was chiselled into each frontal sinus. Upon making the first opening into the sinus a portion of a mucous polypi appeared. The sinus proved to be

full of polypi, granulation-tissue and pus. The sinus was carefully curetted, and washed out with a boric acid solution, and packed with iodoform gauze. The other sinus was found to be in exactly the same condition as the one already described. It was treated in exactly the same manner. No bare bone could be detected in either sinus. There was little odor of the pus. Rubber tubes were inserted in each opening into the sinuses, a dressing applied and the patient put in bed.

He had a slight fever in the evening of the day of operation, but the next morning his temperature was normal, and after this time he had no fever while in the hospital—about eight days. The morning after the operation his face was markedly swollen, especially in the region of the frontal sinuses. He looked like one suffering from facial erysipelas, except that the color of his face was of a dirty reddish hue. I could not account for this reaction, for the greatest care had been used during the operation. This swelling promptly subsided. The discharge from the sinuses was quite copious but always of a good character. He was taught to cleanse each sinus two or three times a day in addition to the syringing out of each maxillary sinus. His apparent recovery for the next eight days was uneventful.

He was at this time allowed to go home and placed in the hands of his family physician. This was on June 1, 1899. He went home and for a week seemed to be doing as well as could be desired. He then developed a slight fever and began to complain of a little headache. He was put in bed and kept there.

On June 13th I saw him in consultation with his family physician. His temperature for the last day or two had been about 102 degrees. He had complained of some pain in his head. I found the left superior frontal region markedly swollen. I removed the rubber drainage tube from the left frontal opening, and upon gentle pressure over the left superior frontal swelling I succeeded in evacuating a superficial abscess in that region. Hoping that the formation of this abscess accounted for the headache and fever, and yet feeling that there was good reason for anxiety, I returned. The evacuation of this abscess seemed to make no change in his condition.

On June 24th I saw him again, with his family physician. He was in articulo mortis. He had a well-marked paralysis of his left arm and leg, and died eighteen hours later. An operation seemed to offer no hope at this time.

He had continued to complain of headache since June 13th,



and had continued to have slight fever and a slight rapidity of pulse, with no other special train of symptoms until two days before my final visit. He then vomited, had a slight chill, and developed a slight temporary paralysis of his left arm. After a few hours the paralysis in his left arm returned and soon involved the left leg. A peculiarity of the paralysis was that while the loss of motion was well-marked, the loss of sensation was out of all proportion to the loss of motion.

*Comments.* This patient had a most marked pathological condition of his nose and upper air passages. His complaint as to his condition was never marked. Patients become accustomed to marked abnormal conditions of the nose and throat and in many cases stoutly maintain that they have no trouble. Patients repeatedly express themselves after relief from trouble they did not know they had by saying, "I did not know I had catarrh." This patient had adenoids although 25 years of age, not simply a few unatrophied adenoids, but as large a mass as is ordinarily found in a boy of 12 years of age.

Adenoids do not atrophy at puberty. They tend toward atrophy, but a very large proportion of cases persist to 25 or 30 years of age. In time they will disappear spontaneously, but in many cases they persist long enough to give rise to a hopelessly chronic middle ear inflammation, a chronic laryngitis, a nasopharyngitis, etc. The time has come for doctors to stop telling people that their children will outgrow enlarged tonsils and adenoids.

This patient had perfectly normal ears. He had enough trouble in his nose and naso-pharynx, five times over, to lead to any one of the possible pathological aural conditions. He also had a normal larynx. This condition of the larynx was no less surprising than that of the ears. This case was simply an exception to the rule that nearly all diseases of the ear or larynx take their origin from an abnormal condition of the nose or nasopharynx, or both. He had a hypertrophic rhinitis. A throat and nose specialist sees cases of hypertrophic rhinitis in which no other condition of the nose or naso-pharynx exists, yet ordinarily the hypertrophic rhinitis is only a small part of the abnormal condition present, and only a factor in the production of the patient's train of symptoms.

He had a nasal polypi. These polypi were overlooked in the beginning largely because of the fact of the occlusion of the anterior portion of each nostril. Their presence was not sus-

pected. Had any suspicion of their presence been entertained, a more complete diagnosis under cocaine could probably have been made. However, it is not always possible to decide as to the condition of the posterior part of a nose before removal of anterior obstructions. From presence of the polypi I at once became suspicious of the maxillary sinuses. Nasal polypi are often associated with an empyema of the accessory sinuses. Authorities differ as to the role they play, some claiming that the disease of the sinuses arises because of the polypi, and others claiming that the polypi arise because of the sinus disease. In my experience, while the above statement that disease of some one or all of the accessory sinuses should be suspected in every case of nasal polypi, I find that only a small proportion of patients who have polypi have sinus disease.

Trans-illumination of the face, when the nasal passages are free, may give helpful information as to the condition of the accessory sinuses. While I make constant use of this means of diagnosis, I never depend upon it. In this case the test was unsatisfactory.

There are two symptoms in disease of the accessory sinuses which are more important than all others, i. e., a unilateral discharge and pus in the nose. Strange as the statement may seem, the majority of patients with an empyema of a single maxillary sinus do not know that they have such a discharge. Neither have the majority of such cases observed any peculiar staining of the handkerchief. While an empyema may occasion headache, facial neuralgia, occipital pain or loss of flesh and strength, the lack of symptoms in such cases is to me a constant source of surprise. There is as a rule no odor that friends detect. The patient himself, especially mornings, may complain of a disagreeable odor, and occasionally a case is seen in which the odor is terrific. Some cases in which neither the patient nor his friends make any complaint have a peculiar, sweetish, mousey odor, which can be detected by the trained sense of the physician.

The amount of the discharge varies within wide limits. When the patient has no cold the discharge may be very slight. Upon taking cold, even after the sinus has been opened and washed out for weeks or months, the amount of discharge is markedly increased. In the case reported the discharge was slight, so much so that no suspicion of sinus disease was entertained before the discovery of the polypi, and even then I considered it probable that the case was one of polypi only, and not of



sinus disease. The fact that I had cauterized the right anterior turbinated and sawed off a ridge from the left side of the septum contributed to my overlooking the pus in the nose.

After any operative interference in the nose, mass formation always results, it may be for weeks. An empyema of the maxillary sinus is the condition that ordinarily occurs, whenever any one of the accessory sinuses is involved. Occasionally one sees a case of disease of each sinus. Associated with an empyema of a maxillary sinus, one occasionally sees an empyema of the corresponding frontal sinus, or an ethmoiditis. In such a case the maxillary sinus probably acts in the beginning as a receptacle for the pus from the disease above. However, the great majority of the cases of empyema of the maxillary sinus observed by myself have no associated ethmoidal or frontal sinus disease. To make a diagnosis as to the condition of the frontal sinus in such a case the maxillary sinus should be washed out so that no pus can reappear in the nose for some little time from this source, then put the patient in an upright position and watch for pus in the former site. If a slight amount of pus reappears promptly it almost surely denotes disease in the frontal sinus.

The best opening into the maxillary sinus is through the socket of a drawn tooth. The sacrifice of a sound tooth is an important matter, but in a disease of such gravity as an empyema of the maxillary sinus, and one so difficult of cure, the loss of a tooth is only relatively important. There is a wide difference of opinion as to the best location for an opening into the sinus. Some operators prefer an opening through the canine fossa; others an opening from the nose into the antrum through the external wall of the nasal cavity. There are good arguments in favor of each point of selection. The great argument in favor of making the opening through the alveolus is that the patient can be taught to cleanse the cavity himself. Upon the careful, systematic cleansing of the cavity for months, possibly for years, depends the success of the treatment. If the patient is taught to cleanse the cavity, you succeed in curing your patient. If you proceed upon any other plan of treatment, the frequent visits to the physician and the expense become so burdensome that many patients will abandon all treatment. The great mass of cases of empyema of the antrum will get well if opened and systematically cleansed. In some cases polypi, necrosed bone, septa dividing the space into more than one cavity may be found. In such cases, which are certainly rare in private practice, a large opening

should be made in the canine fossa, or through the lateral wall of the nose, and the cavity should be thoroughly explored with the finger or electric light, and treatment inaugurated according to the condition found.

This patient undoubtedly died from an abscess of the brain. In common with a certain proportion of cases of cerebral abscess, he had no especial symptoms aside from the slight fever, slight headache and general depression, until the slight temporary paralysis of the left arm occurred. Then, if ever, operative treatment of the cerebral condition should have been attempted. The abscess produced pressure, involving first the arm center and later on the higher leg center.

It would have been easy to decide as to the location of the abscess in this case if operative treatment could have been considered. The abscess must have been located in the motor area, while the disease of the frontal sinus must have been the cause of the abscess. It is probable that the frontal lobe of the brain was healthy. Speculation as to this case might be continued indefinitely. I fear that I have already occupied too much of your time.

The Hickox, Cleveland, Ohio.

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## TUBERCULOSIS OF THE HIP JOINT.

BY H. A. BECKER, M. D.

Visiting Surgeon to the German Hospital; Assistant Surgeon to Out-Door Department, Lakeside Hospital; Demonstrator of Surgery, W. R. University.

During the course of the last year quite a number of cases of tuberculosis of the hip joint have come under my observation. Of this number I to-night take the liberty of presenting to you two, illustrating in the one the benign form of the disease, treated conservatively for a period of fourteen months with a complete cure. The other, the malignant, rapidly destructive type of the disease, with resection of the right hip, resulting also in recovery and a good joint. Before taking up the indications for and treatment in both of these classes of cases, let us dwell for a moment on some clinical observations which occurred to me repeatedly during their course. The one point of vital importance to me seems to be that of the earliest possible diagnosis, for the prognosis becomes the more favorable the sooner the disease is recognized. This must necessarily depend upon a careful and systematic study

of both subjective and objective symptoms. If the patient be sufficiently intelligent to locate pain and describe his symptoms, if the parents are people who can and do observe every little move of their child, they will probably bring him for treatment during one of the early exacerbations of the disease. I say exacerbations because there are very few who, during the early stages of the disease, do not pass through one or more of these. If, on the other hand, the patient be one of a large family and somewhat dependent upon his own efforts for amusement and personal care, with parents, who either do not observe the gradual chain of symptoms developing or are inclined to treat them lightly, he will come for treatment first when the disease has already gotten well under way.

What, then, are some of the earliest subjective symptoms? A cross-examination of the parents will usually reveal the history of a traumatism such as a fall or a stumble, as the probable exciting cause, sometimes so slight and so seemingly insignificant that only the closest questioning will establish it definitely. This is followed sometimes as long as from three to six months by a stage of lameness, or stiffness about the hip, which, after a short duration, improves somewhat and the parents are often deceived into believing their child better. After the subsidence of these symptoms there is a remission of anywhere from several weeks to months when the child, because of its awkwardness and the care necessary to avoid distress, has another slight fall and the first symptoms repeat themselves in an exaggerated form. The mother will say that the child complains of pain in the knee, that she has been hurriedly called to his bedside by night cries and found the patient with the thigh flexed on the abdomen, and the hands holding the knee in an attempt to counteract the muscular spasms or even intuitively to make extension and thus relieve the pain. These exacerbations of course vary in number and individual severity, but all cases are ushered in by one or more. Add to these the fact that the child avoids all active exercise, in fact seems most comfortable in a reclining position with the thigh flexed, or when standing with the body bent forward and supporting himself with both hands on some stationary object; the loss of appetite with resulting emaciation; the family history with a trace of tuberculosis on the father's or mother's side, and our chain of subjective symptoms becomes moderately complete. Considering the objective symptoms as revealed by a careful physical examination, in order to group these more systematically, we divide the dis-



ease clinically into three stages; the first, of no deformity; the second, of slight deformity, and the third, of marked deformity and shortening.

If a correct diagnosis can be made during the first or the early part of the second stage there is every chance for the patient under appropriate treatment to recover, even if after a period of several years, with none or at least very little deformity or functional limitation. Undisputedly the earliest and most important objective symptoms are the temperature, the muscular fixation of the affected hip joint, with resulting lumbar lordosis and the disappearance of the gluteal fold or crease on the affected side. The temperature here, as in all other tubercular lesions, is very characteristic, normal or slightly above in the morning, 99.5 to 100.5 in the afternoon and evening. If the patient has had a period of rest in bed the temperature may be very slight and even entirely absent, but if taken regularly for some time it will show itself sooner or later. In all of the nine cases observed in the past year in the early stages the temperature was present and served as a partial clue to the correct diagnosis.

As the patient lies before you, inspection will show a child of an extremely tender physique; the thin, delicate, almost transparent skin, with rosy flushes on each cheek gives a complexion almost characteristic of tuberculosis. Upon complete extension of the thighs, the first thing to attract your attention will be the lumbar lordosis and an apparent lengthening of the limb on the affected side. Comparative measurements from both spines of the ileum to the internal malleoli will prove negative and in later stages will reveal actual shortening. Pressure over the trochanter or violent percussion of the foot in the long axis of the limb will elicit symptoms of pain. These will, of course, vary again according to the location of the primary focus, whether in the head, neck, greater or lesser trochanter. Grasping the thigh in the one hand and fixing the pelvis with the other you will find all joint functions, flexion, extension, abduction, adduction, pronation and supination possible and normal within a certain limit, but the moment these are increased to their extreme limit the patient will not only cry out with pain, but actual movements of the pelvis will be obtained, brought about by the muscular fixation and reflex spasmodic contractions. Both sides should be carefully and systematically compared, and it is always well to go through the motions on the well side first, so as to gain all possible confidence of the patient and less resistance when the diseased side is examined.

Extreme extension will produce a marked lumbar lordosis and extreme flexion will cause it to disappear, again showing muscular fixation. Inspection of posterior surface of thigh will show the partial or complete disappearance of the gluteal fold due to the flexed position of the limb. When these symptoms are present one can safely make the diagnosis of tubercular hip joint. Later, in the second and third stage of the disease, when actual measurements reveal marked deformity and abscess formation has already begun the diagnosis becomes moderately easy, and the chief question is how much destruction the disease has wrought, for here the practitioner must decide whether the treatment is to be conservative or radical. In cases of long standing abscess formation, a careful examination of the urine should be made for evidences of beginning amyloid degeneration. Conditions to be considered in differential diagnosis are first, myositis of the psoas muscle, whether from infection of inguinal glands, some other primary focus of inflammation or a bursitis of the iliac bursae under the psoas muscle. Here only adduction and extension will cause movements of the pelvis, all other functions will be normal. Second, in Pott's disease of the last dorsal or first lumbar vertebrae only extension is limited. In polio myelitis the well marked history of invasion and the paralysis will help one to a diagnosis. In sciatica the age, the three pressure points and normal temperature will decide for or against.

The treatment necessarily falls under two heads: (a) conservative and (b) radical or operative. In the first and early part of the second stage the conservative treatment is always indicated. In it the problems to be solved are: (a) correction of any deformity, if it already exists; (b) complete immobilization of the affected hip joint by the most suitable means in such a way that the patient can get a moderate amount of out door exercise; and (c) the administration of creosote and tonics. As to the correction of the deformity, nothing will work to greater advantage than Buck's extension, in the line of deformity, with fracture bed, pulley and weight applied on a cart so that the patient can be rolled out of doors. It is true that its use will confine the patient to his bed, but it is only for a short time, and there is no other device which will so quickly and so painlessly correct the lumbar lordosis and muscular fixation. The moment the deformity is corrected, and this usually requires from one to three weeks, comes the problem of immobilization. Numberless splints and braces have come upon the market from year to year, the inventor of each and every

one claiming superiority, but as yet no device has been found which would answer every purpose as the plaster of paris spicca bandage.

When after careful padding, started at the base of the toes and brought up over the free ribs, it will, without causing much discomfort to the patient, absolutely immobilize the hip-joint and stop all muscular contractions. There are five points of vital importance to remember in putting on a spicca bandage in order to make it comfortable. They are, first, to take in the entire foot instead of starting above the ankle; second, the binding of the upper and lower borders of the bandage with some soft material; third, an even layer of sheet wadding under the plaster, thickened over the malleoli, the knee and the spines of the ilium; fourth, to make the bandage of as light a weight as possible without losing the strength at the hip-joint; and, fifth, a point which I have not found mentioned in any literature, is the prevention of the fixation of the knee in complete or over extension because this position cannot but be extremely uncomfortable.

As to the first point, if the entire foot is not taken into the bandage oedema will follow within a few days, and I have seen it so marked that in taking off the bandage the lower end had to be cut out of the raw tissues, over-crowding its border. The same raw surface would be produced by the rough edge of an unbound bandage. A single layer of flannel, cut on the bias, overlapping the edges will entirely prevent this. The three pressure points where a spicca bandage would cause pain and excoriations unless especially well padded, are the malleoli, the condyles of the femur and the spines of the ilium. A few extra layers of sheet wadding at these points will prevent this nicely. One of the strong objections to the spicca bandage has been its weight. When properly applied this will not be such an objectionable feature. The bandage removed from the little patient with the resected hip whom I will show you to-night weighed but  $1\frac{3}{4}$  pounds, and, although it had a window cut into it to allow for dressing of the wound, it was solid and did not break at the hip. To gain the necessary strength without the weight of so much plaster, we inter-weave the strips of basket wood obtained from an ordinary half-bushel basket between the bandages, crossing them at the hip. In this way we get a spicca abundantly strong by applying from six to fourteen ordinary plaster bandages, according to the size of the patient. Add to this a shoe raised about two inches on the sound foot and a pair of crutches, teaching him how to use his hands in



bearing his weight upon them instead of letting it rest in the axilla and thus avoid the crutch paralysis, and the patient has been put in the best possible shape, so that he can get about in the open air, have his daily exercise, and even attend school without any danger of hip motion and irritation. The dexterity developed by these little fellows in handling their crutches and spiccad leg is simply marvelous. With the administration of creosote and an appropriate tonic, fresh country air, milk and wholesome food, the greater number of patients will at once beign to improve rapidly and gain in strength and weight. Their general condition and temperature will serve as a guide to the local condition of affairs. Very often a complete cure is effected by persistently carrying out this treatment, even though it be several years before it is accomplished.

The first case which I present to you to-night is one of this class. He was treated in just the manner described for a period of nine months. During all this time he attended school and could be about. He has now been without a bandage since March, and although he plays and runs about just as other well boys of his age, there has been no recurrence of any trouble. Allow me to say just one word about the administration of creosote in these cases. It was given according to the teachings of Albert's clinic in Vienna, i. e., a solution of two parts of creosote, one part of glycerine and one part of alcohol, 2M. of this solution representing one M. of creosote. From two to twelve drops are thus borne very well, t. i. d. after meals, and is rarely followed by the gastric and intestinal irritation so common with the administration of the pure creosote. In spite of this treatment some cases will go on with evidences of a rapidly destructive process: increased pain, fever and abscess formation, and these, together with the class of cases brought at the end of the second and third stage, are the ones which require radical treatment. Of this class, my second case is an example. He was treated conservatively for a period of some months, when suddenly he grew rapidly worse and developed a large abscess in less than ten days, which had perforated the capsular ligament at the posterior dependent segment, the point of least resistance. I found the articular surface of the head perforated at the place where is shows nicely in the gross specimen. I first resected the head and found the bone still diseased. I next resected the neck and part of the trochanter major. Finding the bone still diseased, I resected below the trochanter major and found healthy bone. I did this on the 8th of August,

and had him on a fracture bed with extension for twelve days, and then put the leg with extension in a plaster spicca for three weeks, with a window over the wound to allow for dressings. At the end of five weeks from the time of operation the bandage was removed and passive motion begun. To-night it is nine weeks since the operation and actual measurements show but one-half inch shortening.

The moment you have evidences of a rapid abscess formation operative interference should be decided upon and all the tubercular tissue should be enucleated. In upward of 80 per cent. of the cases the primary focus will be found somewhere in the head, neck or trochanter of the femur or acetabulum, and in order to save all healthy bone the wisest plan seems to me to be to resect head, neck and trochanter singly. Cases reported from time to time with a tubercular deposit in the soft tissues about the joint are now looked upon as of a secondary deposit only. In a certain number of cases of abscess formation which are progressing slowly and where the abscess is favorably situated, repeated aspirations of the pus and the injection of a solution of iodoform, glycerine and creosote or of 1 per cent. formalin glycerine should be tried just as in tuberculosis of the elbow or knee. This will at times do very nicely, but where the abscess formation is rapid, nothing but resection will suffice. Before showing the cases let me briefly review the points I wished especially to emphasize.

First—The importance of an early diagnosis, based upon a careful family and personal history, objective symptoms of muscular fixation, lumbar lordosis, temperature curve and disappearance of gluteal fold.

Second—The immobilization of the hip at the earliest possible moment, after correcting the deformity preferably by the spicca bandage.

Third—The importance of out-door exercise, good air, milk and the best of simple, wholesome food.

Fourth—The necessity of a radical operation as soon as abscess formation is a positive fact, enucleating the tubercular tissue, however extensive, with the appropriate after treatment of extension, fixation, passive motion and medication.

#### DISCUSSION.

*Dr. Crile:* Dr. Becker's paper covers the salient points very completely. I agree with what the doctor says about the spicca plaster, and especially about its early use in these cases. When

the results are good the patient is cured, and when the spicca fails to relieve, the resource of operative measures still remains. I would like to ask the doctor whether he expects any further trouble in this case?

*Dr. Becker:* No, I think there will be no further difficulty. His temperature has been normal for nine months; he seems quite well now, and he has been in school during the entire time.

*Dr. Tuckerman:* I see that it is stated that the Widal test shows somewhat different reaction in these cases from what it does in typhoid fever. These cases are somewhat difficult of a positive diagnosis in the early stages, and if this test be a true one it will prove very valuable. I see it has been tried in some sixty cases, and that in every case there are signs of suppuration, and that they become of diagnostic value. We would have to eliminate the possibility of the child having had tuberculosis previously.

*Dr. Smith:* I remember seeing a very interesting case of suppuration of the hip joint. Dr. Young had the case in charge. He was a newsboy who had been wandering about, getting very poor fare and sleeping under apple trees or wherever he could find a lodging and who was finally brought to the City Hospital for treatment. He was brought in when several of us doctors were sitting around there, and Dr. Young told us that it was a case of hip joint disease and he was going to operate. This was done, and on opening into the deepest part of the joint, pus began to flow, and kept on flowing until it ran clear down the length of one limb and then along the other and spread out until the entire space between the boy's limbs was filled. There must have been a gallon of pus nearly. As soon as a quantity of the pus flowed out the abdomen began to sink away, and it turned out finally that the trouble had been a psoas abscess. The boy made a good recovery.

*Dr. Bunts:* I would like to ask the doctor in regard to the use of iodoform injections. Two years ago I had two patients at Charity Hospital of the same age, one a boy and the other a girl, and each had an abscess and hip joint disease, and the cases were almost exactly alike. I do not think I ever saw any two cases any more alike in all points. In the one case we decided to use iodoform injections, in the other a spicca plaster bandage. I took every possible precaution to avoid infection, had everything used carefully sterilized, but in spite of all this care there developed a fistulous tract, the case going from bad to worse. The other case



we treated in the manner in which Dr. Becker has treated this case and it recovered. The patient has become well so far as I know. There was a certain amount of weakness for a time, but a year after the child was walking without a brace.

*Dr. Becker:* I did not mean to create the impression that I would prefer iodoform injections. On the contrary, that would not be my choice. My idea was to use this in cases of very slow abscess formation only. I had a case that came to the hospital over a year ago which had an immense abscess, and in which Dr. Allen used iodoform injections. I saw this man this fall, and he had recovered entirely. I doubt, however, if this is usually a good procedure, for I think that the use of iodoform injections in cases of rapid abscess formation is more dangerous to the patient's life than resection and free drainage.

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## A SIMPLE DEVICE FOR RAPID HYPODERMOCLYSIS IN COMBATTING SHOCK.

BY EVAN O'NEILL KANE, M. D., KANE, PA.

All who have tried to administer an intravenous infusion must be aware how difficult a procedure it is under adverse circumstances. It is practicable and safe with suitable aseptic surroundings, a fairly aseptic skin and moderately well filled vessels. The case is quite different as generally seen by the railway surgeon when his patient is in shock.

In a caboose, freight car, shanty or crowded boarding house, amid the fumes of tobacco, foul exhalations, and dust, with an unwashed skin begrimed with cinders and grease, and with the veins collapsed from hemorrhage. Any one who has made the attempt knows the difficulties!

It is for this reason that hypodermoclysis commends itself in emergency work.

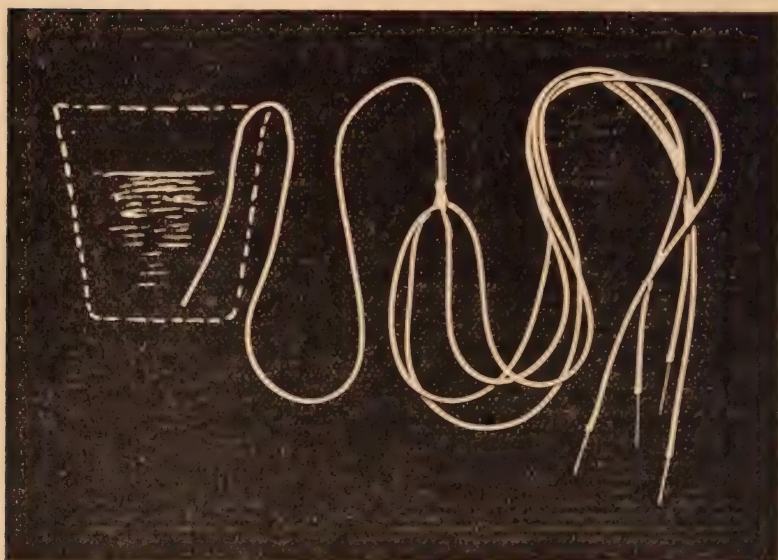
The principal objection to hypodermoclysis has been it is too slow in action where prompt results are demanded. Half an hour is necessary for the instillation of from a pint to a quart (too long a time in a serious case of shock). To obviate this difficulty I have devised a simple apparatus with which four or more needles may furnish fluid to the tissues at the same time from a single receptacle. Anyone with the slightest amount of mechanical ability can construct the apparatus in a few minutes without trouble and at trifling expense.

He will require an ordinary rubber bulb glass medicine dropper, five yards of fine rubber tubing, such as is used for nursing bottles, four extra large hypodermic needles, or fine asperating needles, and a wire hairpin.

The whole apparatus can be sterilized in a few minutes by immersion in boiling water. Any clean bowl, bottle, pail or other vessel of sufficient size will answer for the receptacle that shall contain the normal salt solution.

The construction is as follows:

Into one end of three feet of the rubber tubing (the end



which is to serve as a siphon) is inserted the wire hairpin to act as a stilet in retaining the tubing in the proper curve to hang over the edge of the vessel.

The pin must have first had its curve altered to a more obtuse angle to prevent kinking of the tubing. A few short crooks along each fork will prove of advantage by preventing its sliding through the rubber tubing when subjected to tension. By this device is secured a firm and properly curved siphon which can, by bending the pin more or less, be made to fit over the lip of any vessel.

The length of the short arm of the siphon can be increased or diminished to just reach the bottom of a vessel of any depth by merely sliding the wire a greater or less distance along the tubing.

Into the other end of the yard of tubing is inserted the nozzle of the dropper, the tip of which, if too small, should be broken off to where it is wider. In the rubber bulb of the dropper are cut four openings, each a little more than half the diameter of the tubing. Two lengths of rubber tubing, each two yards long, are now drawn through the holes in the bulb at right angles half their length so that a foot and a half hangs out on each side. (I should add that a notch should first have been cut in the middle of each tube to be drawn, notch upwards, fully inside the rubber bulb.) Finally, to the open ends of the rubber tubing are attached the four hypodermic needles.

An apparatus with four needles can readily introduce from two to four quarts of fluid into the tissues in half an hour. The amount will depend upon the size of the needles, the elevation of the receptacle and the thickness of the cellular tissues. A much larger amount of fluid can be introduced if more needles are employed. In order to show you how we may increase the number in one apparatus I have here one which, by additional branching from the four terminal points, supplies ten needles. I have not, however, for practical purposes, found it necessary to use so large a number. One can conveniently insert one needle into each loin, and one below each scapular, upon each side of the abdomen or under the breasts. It is well to change the location of the needles slightly from time to time to prevent over distension of the tissues.

To start the current through the siphon suction should be made through one of the needles, the points of the others being closed by the finger and thumb. As a precaution against possible sepsis it might be well to make the suction indirectly through the clenched fist.

In urgent cases I elevate the receptacle five feet, but this is objectionable on account of the pain and soreness produced by so forcible distension. The smaller the needles and the less the degree of elevation the less will be the pain to a conscious patient. The rapidity of the infusion will, of course, be correspondingly slow.

When a patient is suffering from shock (usually great loss of blood in railway cases) the surgeon may set the apparatus in action in a few moments and leave it almost without farther attention while he and his assistants are employed about the various steps of the operation.

I carry an infusion appliance in my emergency surgical case and another in my obstetrical bag (I have more than once saved



women in post-partem hemorrhage by its prompt use), while a third is kept hanging in position in my hospital operating room.

Hypodermoclysis cannot act upon the heart instantaneously as if the veins or arteries are filled directly, but the simplicity of application and the greater safety to the patient more than outweigh the slight difference in time in most cases. I question, indeed, whether the additional time required in properly isolating the vessel, etc., does not occupy a greater amount of time even when one has every convenience at hand. There are but few railway surgeons, too, whose experience with intravenous infusion has been sufficient to warrant them in searching for, and attempting to open, a partially collapsed vein amid the hurry and confusion attendant upon most railway work.

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#### SPEECH OF GEN. LEONARD WOOD.\*

*Mr. President and Members of the Association:*—I want to thank you very cordially for your extremely warm welcome, and to tell you very frankly that I have not come, as several gentlemen have asked me, with manuscript. I have come to tell you I am glad to see you all and to be back, though only for a few days. I expect to return very soon to Cuba, where there is plenty of work to do for some time to come; and in that connection I should like to say a word or two about our own profession down there. I had the good fortune to be there during the war and to see something of the men in the medical profession; I did not see a coward or a man shirk his duty either under fire or during the epidemic of yellow fever or in the hospitals of the province. (Applause.)

The medical questions there were serious and peculiar. In a city of fifty thousand people, twenty-five thousand were sick. We had what some of our experts called yellow fever, and others said was pernicious malaria; but there did not seem to be much choice, as the death rate was about the same. Our medical officers went to work with a will. The young women of the United States came down, some without salary, others for a very small salary; and they worked, and took their lives in their hands. It was a rather unusual sight to see two companies from the colored regiment of infantry, after distinguishing themselves at San Juan Hill, turn round and march to the yellow fever hospital to act as nurses. No soldiers in the army went into battle more cheerfully or did better than these in this trying duty. (Applause.)

\* Informal address given at the last meeting of the Harvard Medical Alumni Association, in Boston.

There is a good deal of talk to-day about Cuba, and whether we have any right to be in Cuba. That is a subject I cannot discuss; but, if there is anything in giving people better towns to live in, reducing their death-rate 40 or 50 per cent, making them cleaner and more healthy, and the people I hope eventually better citizens, then there is at least reason for a temporary stay in Cuba. (Applause.)

The medical profession are working very hard down there. Only the other day I left a young medical officer who had just reported. He said he hoped he should be able to see something of yellow fever this summer. I told him I hoped he would not be able to see anything of yellow fever this summer. Yesterday I had a telegram saying he had died of yellow fever. He had volunteered to take care of some cases, and died within two days. The work down there is very trying and very discouraging; but I am glad to say that the medical profession in Cuba are taking hold of it, helping us all they can.

So far as I can judge from a year's residence in the island, there is no reason, barring malaria, why we should not have in Cuba a comparatively healthy country. The water is generally speaking good; the climate is excellent. We do not suffer as much from heat there as here in the summer. The winter climate is delightful. The surface of the country is underlain with soft limestone, which seems to be particularly beneficial. If you have ever been among the Cubans and in the Cuban, or rather Spanish, towns, you will wonder not at the large death rate, but you will wonder that there was not a great deal larger one. I think the same conditions introduced into Boston would result in a death rate much larger than the death rate of Santiago ever was. In other words, I believe we can make that country healthy; and I believe the work we can do while there will be such that all the world will say that the work of the United States in Cuba was a good work and was done in a good way. (Long continued applause.)

*The President:* Could anything be more gratifying than to have the direct testimony, clear and simple, of one of our own sons as to what medicine and our education are doing in tropical countries? (Applause.)

Gentlemen, we will return to the more serious business of the meeting; and I am happy to present to you Dr. H. L. Burrell, who will continue the subject of medical education and the advancement which we hope to attain.

## A TAPEWORM EXTRACTED THROUGH THE MOUTH.

BY DR. E. W. LUDLOW, URBANA, O.

Being asked to prescribe for a boy of 10 who had worms, calomel and santonine were given with the usual directions as to fasting, and a saline after the drugs above mentioned. A report was received the next day that at about noon of the same day, and six hours after giving the calomel and santonine, the boy was taken with a choking spell, exclaiming that he was dying. Opening his mouth it was found full of tapeworm, of which some twenty feet were extracted through the mouth, when the worm broke. In the course of an hour he passed from the bowel a piece fully as long as that which came from the mouth. The worm was brought to me in such a condition that it was impossible to find the head if it was present. After several days rest and preparatory fasting, I gave an emulsion of pumpkin seeds and ethereal extract of male-fern, with the effect only of free purgation. None of the worm has been seen since and over two months have elapsed. The interesting feature of the case was the presence of the worm in the stomach and esophagus. The santonine and calomel probably stirred it up and it lost its way, getting into the stomach, where, on account of the gastric juice, it found its way into the esophagus and mouth.

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**Carbolic Acid in the Tonsil.** Kramer has employed for several years injections of carbolic acid into the tonsil for the relief of recurrent tonsilitis. He reports fifteen cases where there has been freedom from the disease for two years or more. The treatment is based upon the theory that recurrent tonsilitis is due to the retention of micro-organisms in the glands. The treatment was begun several weeks after recovery from an acute attack, and consisted in the injection of carbolic acid 1:40 for two or three days, until from four to six injections had been given. After cocainizing the part the sterilized needle of the syringe was introduced one centimetre into the anterior pillar of the fauces, and if no bleeding followed, the carbolic solution was injected drop by drop, the needle being pushed in several directions until fifteen minims had been injected. There was very little local reaction.—*New York Medical Review of Reviews.*



# THE Cleveland Medical Gazette

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## Editorial.

### THE PAYMENT OF THE DOCTOR'S BILL.

Better times are in store for the doctors. There is to be a gradual reform in the matter of the payment of our bills. That desirable end may not come soon. Some of us may come to our end by starvation or old age in the meantime if we wait for others to do all the reforming. But there can be no doubt that the abuse from which the profession has long suffered has reached its worst, and the tendency now is toward a recognition of the doctor's rights in regard to fees. Individual physicians here and there have made vigorous protests against the evil, whose features have been accurately delineated from time to time. Medical societies have taken up the subject occasionally in a more or less energetic

way. Medical journals have made efforts to propagate sensible views and excite a practical application of them. Even lay publications have gone farther than making jokes and telling stories about doctor's bills and have seriously undertaken to help us and see justice done. It does one good to see an occasional article such as recently came from the pen of the editor of the *Ladies' Home Journal*. Of course its statements are familiar to us, and yet there is a satisfaction in the assurance that our view of the case is not unreasonable nor wholly selfish, as some may allege, but exactly the same as would appeal to the sense of justice, the love of fairness, in any broad-minded layman. Edward W. Bok writes:

"When we are ill the fastest automobile seems to move like a snail in bringing the doctor to us. We are apt to exclaim that we would give almost anything for the doctor to come quickly. His coming is a most welcome presence, and as he alleviates our own pain, or the ills of those we love, we speak of him in unmeasured tones of gratitude. There seems no man for whom we would do quite so much as we would do for him; no one who so thoroughly has our gratitude in his keeping. This is when we are ill, or in the first days of recovery. But some weeks or months after we are well, and when we have almost forgotten how close we were to death's door, and how skillfully the doctor snatched us out of the very jaws of death, the doctor's bill comes along. And somehow our ardor has cooled; we have forgotten the gratitude which swelled within us—and we let the doctor wait.

"For it is an amazing fact that of all bills sent to a family, that of the doctor is in hundreds of families the last one to be paid; and in more cases than it is pleasant to contemplate, it is never paid at all. I have recently gone to the trouble to make some inquiries into this matter, and have been astounded to find that not one-fourth of the bills sent by doctors are paid with anything like promptness. Answers to inquiries addressed to a large number of physicians in all parts of the country showed further that the actual collection of fees was so lamentably small that the facts, if printed in statistics, would scarcely be credited. For instance, one computation showed that in the case of over three hundred physicians one-fifth of their bills were either never paid or were compromised. Yet in all these cases I was careful to consult physicians whose fees were exceedingly moderate, and whose patients were principally those who could easily afford to pay their doctors' bills. In fact, poor people settle their physicians' bills more promptly than do people of large incomes. It was actually sur-

prising to find how many people seemed to have absolutely no sense of duty in this matter. The bills of dressmakers, florists, confectioners, haberdashers—all were paid before the doctor's turn came. In almost all cases the doctor's bill was paid last.

"It is the more difficult to understand this singular negligence, or reluctance, to meet promptly the fees of doctors when one stops to think how the average physician has to work for his money. In fact, there is no class of professional men in any walk of life which is harder worked than are physicians. Their skill and knowledge, first of all, are acquired at a loss of time and money inconceivable except to those who know something of the life of a medical student. When a young doctor hangs out his shingle he has to wait for years before anything like a lucrative practice comes to him. His years of young manhood are practically wasted, for it is with difficulty that a young doctor obtains the confidence of the community in which he is located. And when his practice comes, what does it mean to him? A life spent at the beck and call of any one, at all hours of the day and night, in heat or cold, in rain or shine. No matter how miserable he may feel, he must rise, if he can, and try to alleviate the ill or ail of some one who very often is not half so sick as he is himself. His life is spent in rooms of suffering. He leads, in other words, a dog's life—and worse, because he often goes out in weather when he feels it inhuman to take his horse or his dog. That is the successful doctor.

"And yet such a man, such a factor in our lives, is allowed to wait for his fee, when he presents his bill, for weeks, and sometimes for months. I have often thought in connection with this that, perhaps, if doctors sent their bills at shorter intervals than they now do it might mean prompter payments. Except in cases of protracted illness I have never quite understood why physicians, instead of waiting three, six, and sometimes twelve months, should not adopt the commercial method of presenting monthly bills. For it is unquestionably a trait in human nature which makes it harder to pay a bill six months after services have been performed, and when in many cases those services have slipped from the mind. Be that as it may, and even if it does seem more 'professional' for doctors to submit their bills at long intervals, they ought not to be the people who should be kept waiting for their money. The very fact that they already have waited three or six months should entitle their bills to first or early consideration of payment. If some families kept their grocerymen or



butchers waiting for the payment of their bills as they do their doctors, their credit would soon be looked into and regarded with suspicion. Surely the man who alleviates our pain, or mayhap saves us from death, is entitled to the same consideration as the man who feeds us."

\* \* \* \* \*

"Instead of doing everything we vowed in our illness we would do, we do nothing; we fail to show even the smallest courtesy possible by a prompt payment of our bills.

"There is a quickening of the conscience; a simple realization of a proper sense of duty needed in this matter of paying the fee of the doctor. It is high time, in the case of hundreds of families, that this matter should be brought home to their sense of fairness and justice. And as with them the doctors have for so many years been the last to receive their due in the payment of their bills, it would be only simple justice that hereafter 'the last shall be first.' No worker in the field of human industry deserves better at the hands of the people whom he serves than the doctor, and to pay his fee promptly and cheerfully is the least we can do for the service which he gives us."

The time is coming when a physician will be as much astonished at having to wait six months or a year for his bill to be paid as one of us now would be if a patron were to tender a string of wampum, or a bag of dried apples, or a raccoon's pelt in payment. In other words, the custom of delaying payment of the doctor's fees will become obsolete—a thing of the past; dead and recorded in history—like the offering of sacrifices by the priests in the temples as a means of obtaining health. It will be referred to by our successors as among the sore trials of the profession in times past, as we refer to the fording of unbridged streams and the laborious gathering and preparation of herbs by our forefathers.

But if *we* want to get any benefit of the change in *our* day and generation, we must do something to bring it among us. One of the most sensible steps to take is to adopt the very practical and business-like suggestion quoted, and send our bills at shorter intervals. If all practitioners would render accounts every thirty days, and make an effort to collect them, the desirable change could very soon be brought about. Not all will take the step. Some are too indolent, some too timid. All are willing to be benefited if somebody else will take the trouble and do the work for them. The time is ripe for action. Let the courageous spirits and the energetic take the lead.

KELLEY.

## MEDICINE AS A BUSINESS.

Why is it that so many young physicians, after a few years practice, become discouraged, and renounce their chosen profession to seek employment in other channels? It cannot be that they are all unfitted, or inadequately trained, in a scientific sense, notwithstanding the deplorable fact that a "medical education" may, at present, be so easily acquired and so cheaply bought.

And again, why is it that men of very ordinary capacity are very often seen to attain no mean degree of success, in a worldly sense, and to far outstrip their more learned brothers?

As it is not necessarily the most scholarly men who make the best teachers, but those, rather, who possess the subtle art of imparting that which they do know to others; so in medicine, unless those of high attainments possess at the same time a certain amount of business tact and ability, they are likely to find themselves in the position of the merchant who is unable to secure a market for his wares.

The successful physician must acquire the art of handling people; he must study, comprehend and appreciate the habits, customs, prejudices and superstitions of his locality, in order that he may not needlessly offend, and thereby work himself an unnecessary injury, that may be far reaching in its evil effects.

One's own experience is, necessarily, the best teacher, and it is unfortunate that it is often to be acquired only at enormous cost. But the next best thing is to profit from the experience of others, if by any fortunate chance one may possess himself of them.

Yet where is there a medical school to be found whose curriculum includes a course of lectures upon the essentials of success beyond the training in medicine itself?

In what department of the university is the student impressed with the importance of character? Where is he told that success depends largely upon the personality and disposition of the man himself; upon his tact, patience, industry, honesty, courage, self-control and refinements? And last, but not least, should be included, his business methods.

The dean of one of our foremost medical schools, in speaking upon the subject not long ago, volunteered the opinion that the average medical graduate would be the gainer in the long run if he would remove, after several years' practice, to some distant locality, and then profit by the mistakes of his earlier years. Yet such an undertaking would cost more in time and

money than the average man could well afford. Dr. Maurice Richardson, of Boston, said some years ago, that if ever such a practical series of lectures were introduced into Harvard University, he could easily entertain the class for seven or eight hours with the experiences and consequent lessons that had largely contributed to his own success. And it can not be doubted that any teacher of medicine, of ten years' experience or more, could do the same. Why, then, would it not be an easy matter, as well as a highly practical and useful one, to introduce such a course into our medical schools? Each professor could meet the senior class for one or two lectures during the last year, and the class would thereby have the privilege of listening to men ripe in experience and knowledge, and qualified to talk understandingly upon those matters so essential and necessary to success, and which can not be found in any text-book. G. S. S.

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#### THE SUPERINTENDENCY OF THE CLEVELAND STATE HOSPITAL.

The changes recently made in this position were such as must have kept the candidates, as well as the public, guessing for some time as to how the affair would end. In the first place, the small number of candidates was rather a surprise to everyone, as the place is regarded as well worth having. The salary is small—too small one would think—about twelve hundred dollars a year, but as there are no living expenses to be paid and no office to be furnished out of that, it is equal to two or three times that amount. The duties of the office do not prevent its incumbent from attending to private consultations, or other business matters, giving testimony in court, etc., and he is directly in the way of appointment to a secretaryship or the like. Moreover, to a physician interested in psychiatry the superintendency affords the largest opportunity for the study of his favorite branch.

After Dr. Eyman was transferred to Massillon four of the trustees, Dr. D. S. Gardner of Youngstown, C. N. Schminck of Leetonia, Capt. John Ellen of Willoughby and Hon. C. D. Gassaman of Youngstown, had a meeting and elected Dr. James F. Kelly to be superintendent. This news was still fresh when it became known that the action of the trustees was not altogether approved by the governor. To be sure, Dr. Kelly had been assistant superintendent at the hospital since last December, and so was in line of promotion. His medical career had not been a



long one, since he graduated from the medical department of Western Reserve University in '96, and is only about thirty-three years old. He is an Ohioan by birth and a distant relative of Mr. W. J. Akers, ex-Director of Charities and Correction of Cleveland. He is a single man. It is not thought that the governor had any objection to Dr. Kelly, but merely that he preferred another candidate, Dr. A. B. Howard, of Cuyahoga Falls. When it became evident that the authorities were not unanimous upon his appointment, Dr. Kelly, who had not yet taken the oath of office, very prudently declined to accept the position, saying that he had not sought it in the first place, but only considered it when it came unexpectedly, and he was quite content to remain assistant. Then the trustees had another meeting, and elected Dr. Adams Bailey Howard as superintendent. Dr. Howard was born in Boston in 1860, and, like Dr. Kelly, is still single. He graduated from the Medical Department of Wooster University in 1892, and from then until 1894 he was assistant superintendent at the Cleveland State Hospital. He then established the institution known as "Fair Oaks" at Cuyahoga Falls, which has proven very successful. He was appointed trustee of the Massillon State Hospital in 1897. In his student days he was an attache of the CLEVELAND MEDICAL GAZETTE, and has many friends in Cleveland and Northern Ohio. He entered upon his duties at the Newburgh institution on November 15th.

It now remains to be seen whether the authorities of the new administration will proceed to disarrange the work of their predecessors. If they listen to advice from the medical profession they will let well enough alone, and make no changes in the management of such institutions without good and sufficient cause.

KELLEY.

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#### A NEW MEMBER OF THE PRESIDENT'S CABINET.

This is talked about as a possibility of the near future. The proposed addition will not be known as Secretary of Public Health, nor yet as Secretary for the Colonies, but as Secretary of Commerce and Manufactures. It is said that the merchants and manufacturers of the country have joined with the bankers to advocate the new departure, and recently the New York Board of Trade has taken up the subject and will urge it upon Congress. It would not have been surprising to see a new portfolio created to look after our new colonial possessions, and there might be some

arguments in its favor, but why commerce and manufactures should receive attention of that kind before public health, is not apparent. If it does 'twill merely go to show once again the carelessness of the public in regard to health and the inactivity and inefficiency of the medical profession when it comes to strong-handed influence in politics. If the physicians of this country realized their political power and used it, we would have had a physician as member of the cabinet long ago. But with the usual indifference and spasmodic inactivity prevailing among medical men we may look to see not only a Secretary for the Colonies and a Secretary of Commerce and Manufactures, but a Secretary of Transportation, a Secretary of Religion, a Secretary of Mines and Mining, or a Secretary of Public Amusements before we get a Secretary of Health.

S. W. K.

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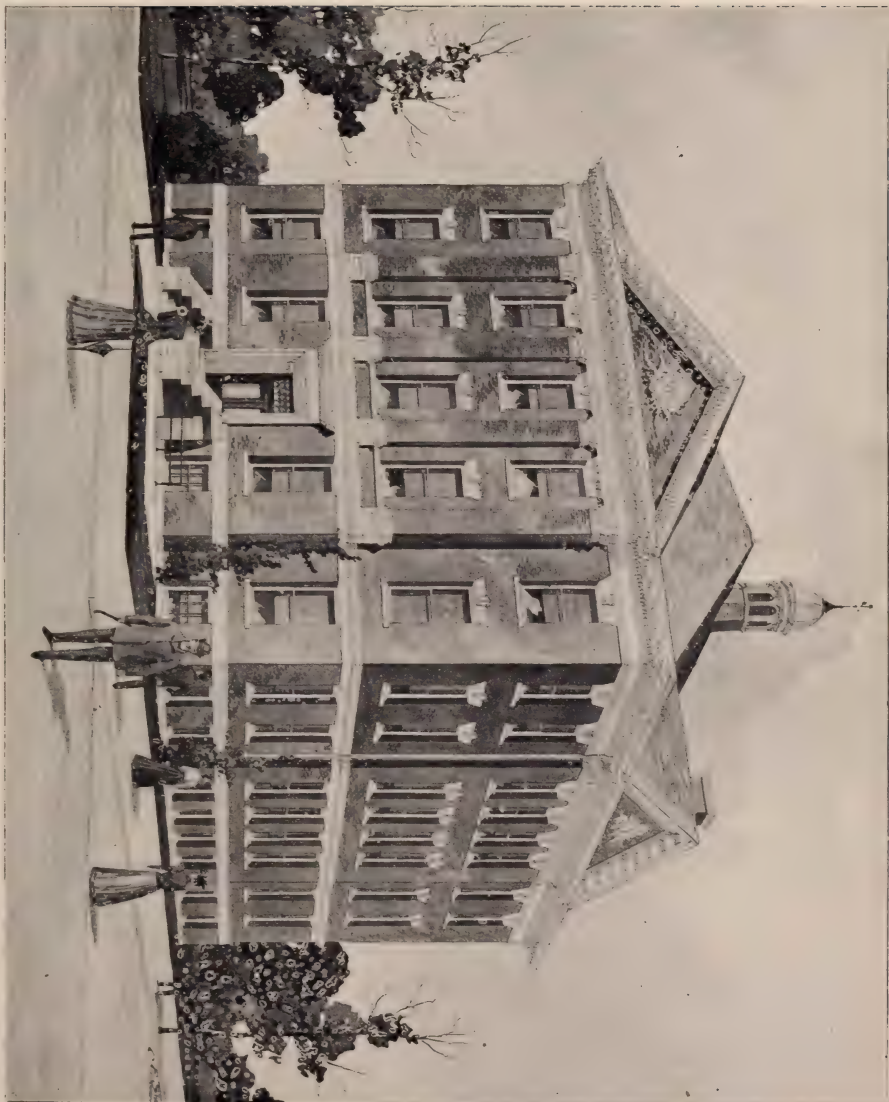
## THE NEW BUILDING OF THE CLEVELAND COLLEGE OF PHYSICIANS AND SURGEONS.

In local medical history the erection of this college building is probably the most important epochmarker of the year. The corner-stone was laid with imposing ceremonies on the 28th of September, by the Grand Lodge of Masons of the state of Ohio, at the corner of Central avenue and Brownell street, opposite the old building. A crowd of several thousand persons witnessed the sight.

The ceremony of the laying of the corner-stone was preceded by a parade made up of the Faculty, representatives of the University, alumni, and students of the college who made the air of the busy streets ring with the college yell, and the Oriental, Holyrood and Forest City Commanderies, a platoon of police and Kirk's Military Band.

Acting Worshipful Grand Chaplain E. B. Bauder delivered the impressive and devout invocation of the ritual, and Most Worshipful Grand Master Edward C. Gulliford began the ceremony proper. The heavy granite stone was raised over the place where it was to rest. On the under side of the stone was a recess for the double copper casket containing a historical sketch of the Wesleyan Methodist Church (which formerly occupied the same site), the announcement of the College of Physicians and Surgeons, the alumni catalogue, the catalogue of the Ohio Wesleyan University, the CLEVELAND MEDICAL GAZETTE, the *Bulletin*

COLLEGE BUILDING OF THE CLEVELAND COLLEGE OF PHYSICIANS AND SURGEONS, MEDICAL DEPARTMENT OF THE  
OHIO WESTERN UNIVERSITY, CORNER OF CENTRAL AVENUE AND BROWNELL STREET.







of the Cleveland General Hospital, *Cleveland Journal of Medicine*, the *Cleveland Leader*, the *Cleveland Plain Dealer*, a program of the ceremonies, the official invitations to the ceremonies, a fragment of the woodwork of the First Wesleyan Methodist Church, a report of the President of the Ohio Wesleyan University for 1899, descriptive catalogue of the University, and copies of an educational and philanthropic paper. After the stone was placed, the silver trowel which was handsomely and appropriately engraved and which had been used in spreading the mortar, was presented to Warren F. Walworth by Grand Chaplain Bauder, with a fitting speech. Mr. Walworth responded with a speech full of the deepest feeling and interest for the future of the College and its Faculty, paying each a very high tribute.

Colonel A. T. Brinsmade then delivered the oration of the day. He referred to the old building in which the college is, under great disadvantages, maintaining its excellent reputation. He also made mention of the great doctors who have been sent forth for the noble work of healing the sick. He added, after predicting a bright future for the College, that with its eminent corps of talented and skilled professors, it is earnestly desired that the fondest hopes of its friends for its success may be more than realized.

"The University can never view with jealous eyes the institution which is a part of itself, even though that institution, its name and fame as the years roll on, shall equal or excel similar ones throughout the country. The institution in central Ohio with which this one is affiliated has sent forth to the world thousands of men and women who have made brilliant records upon the pages of history. When in years to come the names of many of the graduates of this College of Physicians and Surgeons shall become renowned in their chosen calling, then the friends of the University at Delaware, Ohio, will proudly point to the fact that they were fitted for their great work in this College."

He was followed by President Bashford, of the University, whose address was largely historical and statistical. He went back to the time when the University was founded in 1844, with three teachers and twenty-nine students, and traced its rise until now it has thirty-nine teachers and 1,316 students.

"What will we be able to show in the year 2000, when the population of the United States will be 500,000,000, the population of Cleveland 1,500,000, and our church will have a membership of 15,000,000, of which 3,000,000 will be in this state?"

The benediction and the playing of "America" closed the exercises. Since that time work upon the building has gone rapidly forward notwithstanding several delays for want of iron used in the construction.

The handsome building of brick and cut stone, of which we present our readers an engraving this month, exists not merely on paper. At the time of this writing the walls are up and ready for the roof, which will be on before the middle of December if the weather is favorable. Once enclosed, the building can be completed regardless of the weather. It is sixty by ninety feet in size, fronting on Central avenue; and in every particular it is thoroughly adapted to the purposes for which it was designed.

KELLEY.

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## New Books.

**PROGRESSIVE MEDICINE.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. By Hobart Emory Hare, M. D., Professor of Therapeutics and Materia Medica, in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; Laureate of the Royal Academy of Medicine in Belgium; of the Medical Society of London; Corresponding Fellow of the Sociedad Espanole de Higiene of Madrid; Member of the Association of American Physicians, etc. Vol. 3, September, 1899. Diseases of the Thorax and its Viscera, Including the Heart, Lungs, and Bloodvessels—Diseases of the Skin—Diseases of the Nervous System—Obstetrics. Lea Brothers & Co., Philadelphia and New York.

The third volume of *Progressive Medicine* takes up the story of medical progress with diseases of the thorax and its viscera, including the heart, lungs, and blood vessels; diseases of the skin, diseases of the nervous system, obstetrics. Careful examination of the book reveals the story well told in a manner exceedingly attractive and very meaty, containing a deal of very practical information. This volume seems to be up to its two excellent predecessors, and if the future volumes are as well and attractively written, we predict a permanence of *Progressive Medicine*. It was very well said in the preface of the first volume that no medical practitioner, however great his opportunity, could ever hope to accomplish the perusal of but a small part of the periodical medical literature that is published to-day, and the avowed purpose to make *Progressive Medicine* a serial story of the advances of the science of medicine is certainly being fulfilled, and the busy practitioner is being furnished with an enormous amount of carefully



sifted material, told in a clear and comprehensive manner. Young men will do well to buy and read this class of books, particularly so when they appear quarterly, because it will bring to them articles that have been selected by men possessing the necessary judgment to select the writings of those who are real contributors of science.

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**A MANUAL OF ORGANIC MATERIA MEDICA.** By John M. Maisch, Ph., M., Phar., D. Seventh Edition revised by Henry C. C. Maisch, Ph., G., Ph., D., with 285 Illustrations. 523 Pages. Lea Brothers & Co. 1899. Philadelphia and New York.

This old and standard work requires no introduction, it being so well and favorably known.

The superior excellence and authoritative character, so prominent in the older editions, has been retained in the new.

The publishers are to be congratulated in securing such a worthy representative of an illustrious father as reviser.

Profusely illustrated, the compact little volume contains a great amount of most important material, well and distinctly given, and there can be no doubt but that it will continue to be the popular text-book for English speaking schools on this subject.

SPENZER.

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**THE NEWER REMEDIES. A REFERENCE MANUAL FOR PHARMACISTS, PHYSICIANS AND STUDENTS.** By Virgil Coblentz, A. M. Phar. M., Ph. D., F. C. S., etc., Prof. Chemistry and Physics New York, College of Pharmacy; Member of Chemical Societies of Berlin and London, etc. Third edition; revised and enlarged. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

When we remember that during the past ten years, synthetic preparations and proprietary articles to the number of 150 or more per year have been placed on the market for the use of physicians, we can understand the need of a work of this kind.

This work brings together as far as possible those articles, giving their sources, methods of preparation, incompatibilities, medical properties and doses, giving a fair working knowledge of each.

The section on organo-therapeutic agents is especially fine and complete.

The book is well arranged and is handy for reference.

A COMPEND OF OBSTETRICS. By Henry G. Landis, A. M., M. D., revised and edited by William H. Wells, M. D. Sixth edition. Illustrated. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

The fact that this little work has reached its sixth edition reveals its popularity. It is an eminently practical little work, worthy of perusal and containing everything in as small a space as possible, for the correct understanding of the science and art of obstetrics. The following subjects have been rewritten and enlarged, bringing the work up to date: The diagnosis of the various positions and presentations by external manipulations; differential diagnosis between pregnancy and abdominal tumors; obstetric operations; puerperal fever and septic infections.

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MANUAL OF ORTHOPEDIC SURGERY. A TREATISE ON DEFORMITIES AND DISEASES OF JOINTS AND BONES. By Stewart Le Roy McCurdy, A. M., M. D., Pittsburg, Pa. Prof. Anatomy and Oral Surgery, Pittsburg Dental College; Orthopedic Surgeon to Presbyterian Hospital; formerly Prof. Orthopedic Surgery, Ohio Medical University, etc., etc.

This little work of 350 pages aims to give in a brief way the essentials of Orthopedic surgery. It is written in a plain, concise style rendering it suitable for a quick reference, in a small space for the busy practitioner. It lays no claim to treat exhaustively of the subject, yet presents clearly all the essentials of the subject, and the time spent in reading this work is well invested.

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## **Society Proceedings.**

May L. Bassett, Medical Reporter.

### **CUYAHOGA COUNTY MEDICAL SOCIETY.**

*November 2, 1899.*

The meeting opened with the President, Dr. Bunts, in the chair. The minutes of the last meeting were read and approved. Drs. W. E. Bruner and Fred. C. Herrick were elected to active membership.

Dr. G. W. Crile addressed the society briefly, giving his observations upon "Four Hundred Laparotomies." This paper will be published in full in a subsequent number, and also the discussion following.

Dr. Henry A. Becker read a paper entitled "Tuberculosis of the Hip-Joint, with Report of Cases," which is published in full in this number, with the discussion.

Dr. Windisch presented a case of keloid for Dr. W. T. Corlett, and made the following remarks:

In the absence of Dr. Corlett I have been requested to present this case to-night. This is a case of keloid. Keloid was first described by Alibert. The so-called "keloid" of Addison we recognize to-day more properly as scleroderma. Many of these cases of keloid follow acne, and this young man is pretty well covered with acne scars, which in his case seem to be the foundation of these keloid formations. The etiology of this disease is still quite obscure. It attacks both sexes alike, but is more common in the negro race than in the white.

Of the pathology not much more can be said. Some authorities think keloid will be recognized as a cutaneous tubercular disease.

In reference to the treatment, many courses have been pursued. Removal by cauterization or excision are not very successful, but small keloids have been successfully removed with the knife. Salicylic acid, mercury, lead and iodine ointments have been used with very little success. The treatment we have been following is that of scarification. It requires repeated scarifications to produce any effects.

You will notice the numerous scars the young man has upon his back, face and neck. These are acne scars. Whether these will also develop into keloids is a question I can not answer, and why they should not when the others have done so I can not explain either. As a rule these are not painful. They start many times from some irritation, as in this case, where the young man has been tattooed.

Scarification will probably reduce these nodules a great deal, but the operation must be frequently repeated.

*Dr. Oswald:* Are these developing continually?

*Dr. Windisch:* No, they have stopped coming.

*Dr. Bunts:* If the keloids have stopped coming it seems to me it would be worth while to excise them. I remember the case of a man, a railway employe, who began having keloids after being scalded, and we excised them. Some of them were extremely large—one in particular was so large that I put skin grafts from the thigh upon it. There was no tendency to a return of keloids, and none occurred where I took the grafts out. The question of operating in this case seems to me to depend upon the question of whether he still has the tendency to develop keloids,



and I suppose we have no way of deciding that question except to operate.

Dr. Tuckerman moved that hereafter members who wished to present cases should be allowed the first place upon the program so that patients might be allowed to leave early, instead of being obliged to await the regular order of exercises. This was seconded and carried.

Subject for next meeting was announced, it being "Syphilis."  
Meeting adjourned.

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## WARREN COUNTY MEDICAL SOCIETY.

*Meeting October 31, 1899.*

### THE QUESTION OF OPERATION IN INTESTINAL OBSTRUCTION.

Dr. H. J. Death read a paper on "Intestinal Obstruction," in which he gave the history of a case of obstruction occurring in a lady of middle age. After resorting to the ordinary remedies to overcome the condition he had told her that an operation offered her her only hope of recovery. The proposition, however, was promptly declined, and the doctor continued to give her such treatment as the symptoms demanded from day to day. To his great gratification, the woman did not die, but after a time the bowels began to move, the obstruction was relieved, and recovery eventually took place.

This report was made with the intention of bringing up the question of operation in just such cases. Considering the final outcome of this case would it have been the proper thing for him to have insisted upon having an operation done?

Dr. E. S. Stevens said that considering the fortunate termination of the case the question could hardly be fairly raised. Yet in a case of obstruction of the bowels where other means have failed, the treatment by operation ought to be considered. However, there were cases where one should not be hasty in advising a resort to abdominal section, not only because the apparent obstruction may be a condition which will right itself in a little while, but because a too hasty resort to the operating table may end a life that might have been preserved by a delay sufficient to make suitable preparation for the operation. As the paper was being read the speaker was reminded of his only fatal case of appendicitis in a number of cases upon which he had operated. The physician with whom he had seen the case had been called to it a month before he had called for consultation. At that time there was a tender mass in the right iliac space. Within twenty-four hours the

mass was indistinguishable, and the bowels greatly distended. Believing the person, a boy of eleven years, would die, he had tried to ease him along until the end should come. A month passed with little change, and then the idea of operation was placed before the patient and his parents. When the speaker was called he concurred in the diagnosis of appendicitis, and declared his belief that the child would die if operated upon, or if left alone. As there was evidently pus present, however, he agreed with the other physicians present that there might be a little more chance of life if the peritoneal cavity was opened. But the result was death the same day. Since that time he had learned better, and in another similar case he should decline to operate until the intestinal paralysis was overcome, for these cases, when cut, all die. So here was one of the kinds of cases, in addition to the one reported by the essayist, in which an operation should not be done, although obstruction of the bowels, more or less complete, was present from intestinal paralysis, the paralysis due to a diseased vermiform appendix.

Dr. Otho Evans had seen the case referred to in the paper. The physique of the patient was such that it was a matter of course that the diagnosis was difficult to make. He believed this case was one of volvulus. We frequently see cases where the bowels will not move in spite of the thorough use of cathartic medicines. It had been his practice, when by the use of enemas he had not succeeded in moving the bowels, to resort to the use of opiates for the purpose of quieting peristalsis. He had seen several cases where he believed there was invagination of the intestine in which this procedure had restored the bowel to its normal condition and relieved what threatened to be a serious obstruction.

#### A CASE OF HYDATIDIFORM MOLE.

Dr. Otho Evans then presented a "Report of a Case of Hydatidiform Mole." He had been called to see a young married woman who had the general appearance of having perfect health. She was in her sixth week of pregnancy, and was suffering from slight hemorrhage and considerable mental perturbation. Rest and encouragement promptly relieved her.

In April, one month later, a similar attack came on, the hemorrhage being more profuse, and the pain greater. Again the recumbent position and opiates quieted her, but not so promptly.

The month of May passed without trouble, but the end of the month found her more enlarged than he should have expected for that period.

During June she was attacked by severe pains and sharp hemorrhage and he received a history of something having been thrown off, but no fœtus had been found. There was more of the same kind passed later, which he had the opportunity of examining, and which proved to consist of nearly a pint of cysts connected to a common membrane by pedicles, the cysts varying in size from that of a bean to that of a large grape. It was evidently a case of uterine hydatids. One month later the patient's normal monthly flow had resumed.

The case was reported because of its novelty and infrequency. In the course of an obstetrical practice extending over forty-six years, he had never before observed it. Madame Boivin had seen it twice in twenty thousand cases, and at Charity Hospital, Berlin, it had been seen four times in more than twenty thousand cases. But more modern authorities state that it occurs once in two or three thousand cases.

He then spoke of the various views as to the pathology of the affection.

In regard to the treatment it was necessarily expectant because of the difficulty in diagnosis. Hemorrhage should be controlled by rest and by acidulated drinks, if not too severe, in which case the tampon should be employed. On the appearance of cysts and the certainty of the diagnosis the uterus should be emptied, and the case treated as an ordinary abortion.

Dr. B. H. Blair considered it quite an interesting case. He had seen one case in a woman who had previously borne no children. When called to the case he had believed it to be a threatened abortion. She passed something which he did not see. He tamponed, and later she passed about a handful of cysts. About a year later the woman was delivered of a foetus at term.

#### DISLOCATION OF THE CUNEIFORM BONES.

Dr. B. H. Blair read a paper on "Dislocation of the Cuneiform Bones."

The paper was suggested by the following case: A carpenter, forty-three years of age, fell from the roof of a barn to the ground seventeen feet below, alighting upon his feet. He was stunned, and after being carried to the house the essayist was summoned to attend him. Bony prominences were observed upon the dorsum, and upon the inner side of the right foot below and in front of the inner maleolus. The foot was slightly shortened and adducted with the heel elevated, somewhat resembling talipes equinovarus. Examination showed the internal cuneiform bone displaced inwardly, backwardly and upwardly and entirely separ-



ated apparently from its anterior and external attachments. The two other cuneiform bones were displaced upwardly, being raised about half an inch above the dorsal surfaces of the neighboring bones.

Calling to his assistance Dr. E. S. Stevens, an anaesthetic was given and an attempt was made to reduce the dislocated parts. The internal cuneiform was easily placed in its proper position, but would slip back as soon as pressure was removed. But the other bones could not be moved from their new unnatural positions in spite of careful and forceful manipulation in every way that the ingenuity of both physicians could devise. It was therefore determined to leave the parts in as nearly a natural position as possible and give him as useful a foot as could be. The result was a rather thickened but a useful foot.

This is one of the infrequent dislocations. So much so, indeed, that some text-books on general surgery do not mention it at all, while others dismiss the subject with a few lines.

In looking up the subject he had found no account of a case altogether similar to the one just reported where the internal was separated from the middle bone.

The cause of the dislocation is usually direct violence, as a fall from a distance upon the foot, or the dropping of a weight upon the dorsum.

The prominence upon the dorsum or inner side of the foot are characteristic signs.

Replacement is sometimes easy, but occasionally impossible. It is to be effected by extension, manipulation, and pressure. Fixation in plaster of paris, paste-board, or other dressing for from six to eight weeks is necessary. Even when reduction is impossible, a fairly useful foot can usually be expected. Occasionally resection of the luxated bone is desirable when reduction is impossible.

Dr. E. S. Stevens, having seen the case just reported, wished to corroborate what the essayist had said regarding the impossibility of reducing the dislocated bones with safety to the foot. And when the many reasons for this are considered in the anatomy of the foot, it may well be understood that a small bone of the tarsus may be dislocated in such a manner as to be reduced with much greater difficulty than are dislocations of some of the larger bones. A rough drawing of the foot which the speaker had made at the time he saw it with Dr. Blair showed very closely the appearance of the foot with this dislocation.

Eucephalocoele. Dr. Austin Roberts reported this, inasmuch as the tendency of the society for the day was to give their experiences with unusual cases. Being called to an obstetrical case he discovered, upon examination, what seemed to him to be a placenta presenting. Upon the birth of the child it was discovered to be the unusual case of an eucephalocoele. The child lived about two days.

R. E. STEVENS, Sec'y.

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## Notes and Comments.

Dr. J. C. Dreher is located at Plainwell, Michigan.

Dr. Conn R. Ohliger, P. and S., '98, is practicing in Portland, Oregon.

Dr. L. K. Baker has removed his office to the Permanent building.

Dr. John Elliot Woodbridge is now at Dewey Hotel, Washington, D. C.

Dr. Harry P. Hanson, P. and S., '97, was recently married at Glenville, Ohio.

Dr. W. H. Humiston's eldest daughter is suffering from a mild attack of typhoid.

Dr. Chas. G. Foote, after suffering a severe attack of tonsillitis, has gone to Sagertown for a short stay.

Dr. George N. Simpson, P. and S., '98, who was formerly located in Warren, Ohio, is now in Salina, Kansas.

Dr. H. F. Biggar, P. and S., '96, was married Oct. 19th at Trinity Cathedral to Miss Anna H. Ely of this city.

Dr. Herbert T. Thornburgh, College of Physicians and Surgeons class of '98, has recently gone to the Philippines as Contract Surgeon.

Dr. H. J. Herrick, Jr., sails Dec. 4th on the Atlantic transport steamer Marquette for London, where he will spend the winter in special study of the eye.

**Dr. D. N. Kinsman**, of Columbus, addressed the Eastern Ohio Medical Association at its last meeting. The next meeting will be held in Steubenville on the second Tuesday in January.

**Dr. J. E. Witham**, of Harveysburg, has been elected President of the Warren County Medical Society. We hope to see this organization take a new start and exhibit some good scientific work and active interest.

**Dr. W. C. K. Berlin**, P. and S., '95, who acted as surgeon in the Cuban war, enlisted in October as a private in the U. S. army and sailed for the Philippines. The doctor has since been promoted to the rank of First Lieutenant.

**The North Central Ohio Medical Society** will meet Dec. 22, at Shelby.

**To Remove the Odor of Iodoform from the Hands.** Dr. Ricketts is authority for the statement that vinegar applied freely to the hands after they have been cleansed with soap and water will effectually remove the odor of iodoform.—*Medical Review*.

**The Tuscarawas County Medical Society** held a very interesting meeting at Dennison on Oct. 24. Its meetings are held quarterly, and it was never in more flourishing condition than at present, with Dr. G. F. Lower as President and Dr. H. A. Mackaman as Secretary.

**The Alumni Association of the Cleveland College of Physicians and Surgeons**, through the efforts of Dr. Kelley, Dr. Scott and others, took active steps to increase the interest of the members. As a consequence we are greatly pleased to note that the different class historians are preparing something interesting for the coming annual meeting. It seems probable that the next will be the most interesting and the most enthusiastic reunion in the record of the association.

**Accessions to the Cleveland Medical Library since August, 1899.** Dr. Dudley P. Allen has presented the following new works to the Library:

Holt, L. Emmet—Diseases of Infancy and Childhood.

Phelps, Charles—Traumatic Injuries of Brain and its Membranes, with a Special Study of Pistol-Shot Wounds of the Head in their Medico-Legal and Surgical Relations.

Herrick, James B.—A Handbook of Medical Diagnosis for Students.

Helferich, H.—Atlas of Traumatic Fractures and Luxations, with a Brief Treatise.



Fowler, James Kingston, and John Rickman Godlee—*The Diseases of the Lungs.*

Krafft-Ebing, R. von—*Psychopathia Sexualia, With Special Reference to Contrary Sexual Instinct: A Medico-Legal Study.* Translated by C. G. Chaddock.

Robinson, D. H.—*The Latin Grammar of Pharmacy and Medicine.*

Krieger, George H.—*Blood Serum Therapy and Antitoxins.*

Hayem, George—*Physical and Natural Therapeutics, etc.* Edited by Hobart Amory Hare.

Taylor, Robert W.—*A Practical Treatise on Sexual Disorders of the Male and Female.*

Osler, William—*Lectures on the Diagnosis of Abdominal Tumors.*

Pollock, James Edward, and James Chisholm—*Medical Handbook of Life Assurance for the use of Medical and Other Officers of Companies.*

Denison, Charles—*Climates of the United States in Colors.*

Hektoen, Ludvig—*The Technique of Post-Mortem Examination.*

McGillicuddy, T. J.—*Functional Disorders of the Nervous System in Women, 1898.*

Deaver, John B.—*A Treatise on Appendicitis.*

Abbott, A. C.—*The Hygiene of Transmissible Diseases: Their Causation, Modes of Dissemination and Methods of Prevention.*

Penrose, Charles B.—*A Text-Book of Diseases of Women.*

Dacosta, John Chalmers—*A Manual of Modern Surgery, General and Operative.*

Hare, Hobart Amory—*Practical Diagnosis: The Use of Symptoms in the Diagnosis of Disease.*

Warren, J. Collins and Gould, A. Pearce—*The International Text-Book of Surgery by American and British Authors, Edited by . . . . . Vol. I. General and Operative Surgery.*

Hyde, James Nevins, and Montgomery, Frank H.—*A Practical Treatise on Diseases of the Skin. For the Use of Students and Practitioners.*

Cushny, Arthur R.—*A Text-Book of Pharmacology and Therapeutics, or the Action of Drugs in Health and Disease.*

Drs. C. J. Aldrich, C. B. Parker, C. A. Hamann, and the Surgeon-General, U. S. A., have contributed the following books:

Church, Archibald, and Frederick Peterson—Nervous and Mental Diseases.

Eckley, W. T., and Corinne Buford Eckley—Practical Anatomy. Including a Special Study of the Fundamental Principles of Anatomy.

Progressive Medicine, September 1899.

Catalogue of the Surgeon-General's Library. Vol. 4, Second Series. D-Emulsions.

**A project of unusual value to consumptives**, an evidence of enterprise, is about to be launched in Colorado and New Mexico. It is the establishment of a line of sanatoria, or better, plantations, extending from Denver south, furnishing the necessary tools, implements and supplies for farming, gardening and ranging; giving a healthful employment to those compelled to seek this region and allowing them compensation for their labor. The placing of the proper climate within the reach of every phthisical who can afford the price of transportation is a long step in the cure of disease by natural means. Capital and influence have been interested, markets for the products assured, and under the supervision of energy and ability definite arrangements are expected by the first of the year. If an ideal home and occupation for the victim of pulmonary disease can be realized this certainly offers the greatest hopes of success. The combination of the high, dry climate of Colorado with a means for out of door employment, and this so organized and administered as to be within the reach of all, is a valuable idea and one well worth the especial notice of every physician. We shall note its further development with interest.

**Too Much of a Good Thing.** The fact which the profession should face for their own protection is that there are now about twice as many physicians in America as are necessary for ten years to come. Pity that a few of those medical colleges which are simply designed to put money in the pockets of the stockholders who in most instances constitute the faculty, cannot be shut down for an indefinite length of time. A professorship in the average medical college is a matter of dollars and cents. It represents the purchase of so many shares of stock, and the annual reports of these professors are a matter for mirth. There is too much of the "quorum magna pars sui" spirit in them. The old doctor is a type of the helpful man that is in some danger of becoming extinct.—*Suggestive Therapeutics.*

**The Removal of Blood Stains from Clothing.** J. T. Rugh, in the *Philadelphia Medical Journal* of August 12, 1899, says that hydrogen peroxide will remove blood-stains from linen or other fabrics. The earlier the application is made the better the result, but even old blood-stains may be completely decolorized by this method. The peroxide should be used full strength and the application repeated until the stain is entirely obliterated, this being hastened by rubbing the spot with the finger or a cloth during the application. If hot water has been used, or anything that will coagulate the albumen, the peroxide will not remove the stain. By this method he has often removed spots from the shirt-front, collar, and cuffs, and after the surface had dried there was no evidence of soiling. The color of fabrics is not changed by the peroxide.—*Ex.*

**The Cold Wave of February, 1899.** Dr. Guy Hinsdale, before the American Climatological Association (*Boston Medical and Surgical Journal*, September, 1899), traced the meteorological conditions leading to this cold wave, and showed the effect on the community in the loss of life. One hundred and four persons perished between January 29 and February 4. Twenty-four of these died in Colorado by freezing to death and by avalanche; in Texas 15; in Pennsylvania 11; and in New York 10. The hardships from scant food and fuel supplies were more wide-spread than in any other cold wave of which we have record. New minimum temperatures were established in different places: Washington, minus 15 degrees; Baltimore, minus 7 degrees; Philadelphia, minus 6 degrees. The snowfall began February 11, at 9 p. m., and continued for three days, during which time 18.60 inches fell. The wind was from the northeast and blew at times at the rate of 60 miles an hour. The lowest barometer was 29.92 inches. The estimated financial loss in Philadelphia was \$2,500,000, and in the country at large about \$20,000,000. Food rose in price, and there was a shortage in meat, coal, milk, fresh vegetables, oysters, fish, and flour. Ice was noted passing New Orleans on the 17th of February, flowing on into the Gulf of Mexico, an event which had never been witnessed before. Ice an inch thick formed at the mouth of the Mississippi river, and the temperature fell to ten degrees. There was a fall of snow at Jacksonville, Florida.—*Ex.*

**Ether Drinking.** To the evils of alcohol are now added the evils of ether drinking, which has spread alarmingly in eastern Prussia, where ether is sold in the saloons, like any liquor, four



or five grains to the glass. In the town of Memel alone, it is stated, the amount thus sold last year was 8,580 liters, and in reality twice this amount was consumed, the rest brought in by smugglers. The effect is said to be four times more powerful than any equal amount of alcohol, but its continued use produces intolerable suffering and incurable lesions of liver, kidneys and heart.—*Jour. de Med. de Paris, September 3.*

**In Difficult Diagnosis** between measles and scarlet fever Dr. Donkin points to the fact that the region of the nose is always occupied by eruption in measles and the lips peel in scarlet fever.—*Medical Times.*

**Disinfection of the Mouth.** C. Roese announces that numerous—about 264—tests with various disinfectants for the mouth have convinced him that 50 per cent alcohol is not only powerfully bactericidal—as others have established—but that it has a specific healing effect on the diseased mucous membrane of the mouth, producing an arterial fluxion, under the influence of which the venous stasis of the diseased gums disappears and they return gradually to normal. It is impossible to rinse the mouth effectively with it on account of the smarting of the roof and sides of the mouth, but the gums are less sensitive, and his method of applying it is to have the tooth-brush dipped in the alcohol. He urges chemists to devise some preparation for a tooth cream combined of alcohol, precipitated chalk and an appropriate antiseptic.—*Muench. Med. Woch., September 5.*

**The Epidemic at Plymouth, Pa., in 1885.** In the spring of 1885 the mining town of Plymouth, Pa., of about 8,000 or 9,000 inhabitants, was visited by an outbreak of typhoid fever of explosive violence. The sudden appearance of the epidemic, its rapid spread, and the ultimate demonstration of the underlying cause, make it one of the most instructive of the many cases of this kind that have been recorded. From 60 to 100 new cases occurred daily, and on one particular day 200 fresh cases were reported. At least 1,000 of the 9,000 inhabitants were stricken down with the disease. The circumstances surrounding this outbreak were of such a character as to point directly to the drinking water as the channel of infection.

• The facts that were elicited upon inspection of the town and its surroundings were as follows: Conspicuous among the data recorded was the fact that while the disease was generally distributed through the town, it occurred, practically, *only in the*

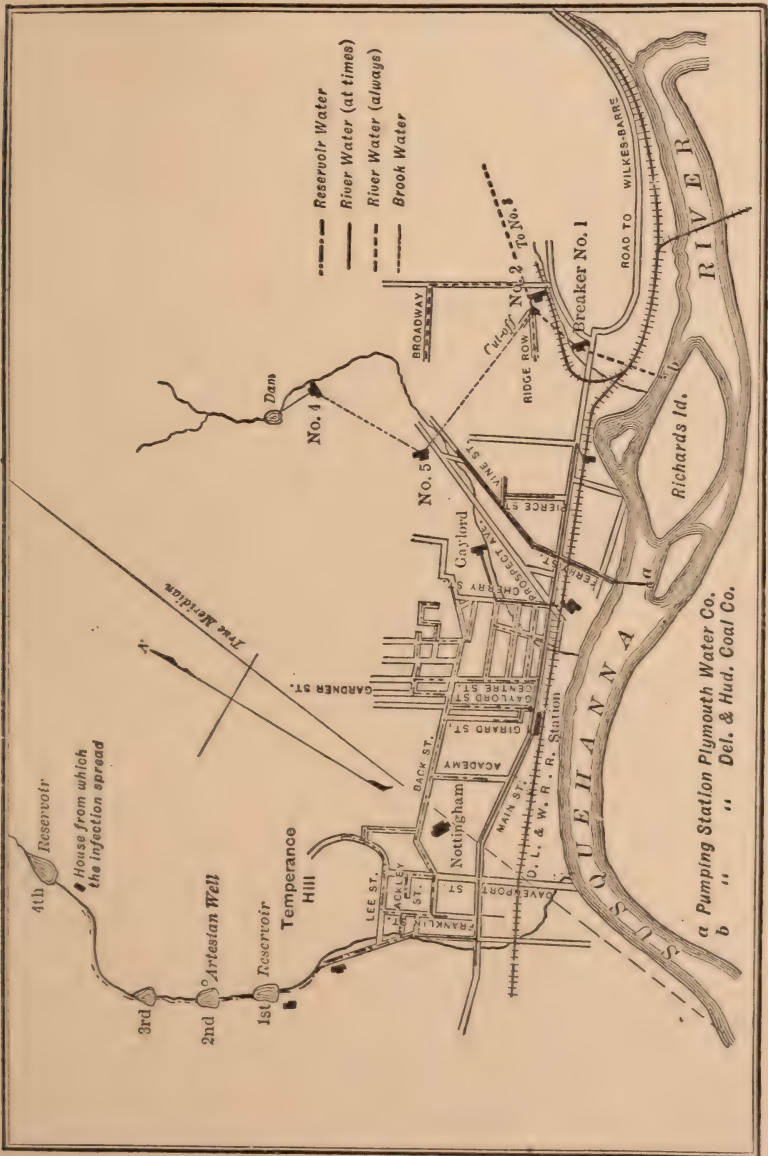
*houses that received their water-supply from one special source, i. e., the general water-supply of the town that is obtained from a series of reservoirs situated along the course of a rapidly-flowing mountain stream that skirts the southwest margin of the borough.* From these reservoirs it is distributed in pipes in the usual way. It was also noticed in those houses receiving their water from other supplies or those having private wells, either no cases of the disease occurred, or where they did occur, it was only among the members of the family who drank of the general supply while away from their homes, during the business hours of the day. During the course of the epidemic it was not unusual for the disease to appear in almost every house on one side of a street supplied with water from the reservoirs, while in those on the opposite side having private wells not a case appeared.

In short, the disease appeared only in those persons who drank of the hydrant water from the reservoirs along the course of the stream mentioned. Upon further investigation it was discovered that between the third and fourth reservoirs and about forty feet from the banks of the stream was located a solitary house in which there had been, some weeks prior to the outbreak, a case of typhoid fever. The facts that were elicited were these: One of the occupants of this house, a man, had visited Philadelphia on December 25, 1884, and while there had contracted the disease. He returned to his home in January and was ill with typhoid fever for many weeks. During the course of his illness, according to the statements of the nurses and attendants, the dejecta that were passed during the night were thrown upon the snow within a few feet of the stream supplying the town with drinking water, while the daily evacuations were emptied into a privy, the contents of which lay upon the surface of the ground. From March 21 to March 23 the temperature of the atmosphere became sufficiently elevated to melt the snow that up to this time had been frozen hard, and during the early days of April there were frequent warm showers. In consequence of these atmospheric conditions the entire mass of dejecta that had been passed during the course of his illness was washed directly into the stream supplying the reservoirs from which the town obtained the largest part of its water.

The amount of pollution was therefore exceptionally great, and the disease-producing elements must have been disseminated by means of the water very shortly afterward; at all events, the epidemic that was obtained shows that the first cases of the epidemic appeared within from two to three weeks—the period of in-

cubation of typhoid fever—after the polluted water had been distributed through the town.

The accompanying is a chart of Plymouth, with sources of its water, and the distribution of the polluted supply marked-----  
 From Abbott's "Hygiene of Transmissible Disease."





**Newspaper Doctors.** It seems that there are certain members of our profession—some of them good men and in every way, except their newspaper advertising weakness, strong men—who are given to periodical manias for advertising themselves in the daily press. Perhaps some new cure for hydrophobia, an idea obtained during a sojourn in Europe, creeps into their brain and they immediately, through the medium of cigars or a bottle of whisky, creep into the daily newspaper with a long account of a new discovery. A distorted blood cell found under the microscope, and they rush for a reporter. Shame on these men! They are a disgrace to themselves and to the profession, but so long as time lasts we must be infested, or, rather, troubled by these parasitic neophytes. Usually these individuals try to be respectable so long as they can work the medical profession and the newspapers and the laity, and maintain their grip on the County Medical Society; but when at last it comes to a show-down—and sooner or later it does—and they are compelled to choose between conducting themselves ethically or stepping down and out, they generally choose the latter and spend the rest of their lives carping and prating about the narrowness and meanness of medical societies, the medical profession and the ethical doctors.—*The Denver Medical Times.*

**Treatment of Nose-Bleed.** Gallaher describes the following method of arresting nasal hemorrhage: A piece of cotton as large as the patient's little finger is taken and a piece of string six inches long is tied to its center. The cotton is then introduced through the anterior nares until it is free in the nasopharynx, gentle traction is then made on the string until the cotton is engaged in the posterior nares, which can be told by resistance or by direct vision. I then blow in an antiseptic powder, and pack, against the plug, sterilized gauze in a long and narrow strip. More powder is blown into the meshes of the gauze as we pack to the front. The string should be wrapped around the index finger of the operator, and he should make sufficient traction to hold the posterior plug in place, lest the plug be dislodged and forced into the nasopharynx, defeating our purposes. When we have packed to the anterior nares a pledget of cotton will be all that is needed. In cases in which the hemorrhage has not been alarming, it is well to remove the plug in twenty-four hours. In graver cases it may be left for forty-eight hours, without much danger of producing acute inflammation of the middle ear. The packing should be removed

with the utmost care, and in nearly every case its removal is not followed by additional hemorrhage. I first thoroughly saturate the gauze with an antiseptic solution, such as boracic acid, following this up with an injection of 2 per cent. solution of cocain, using it from time to time during the removal of the gauze. I also inject an oily solution such as liquid vaselin. When the posterior plug is reached an additional injection of the oil should be made; then the plug can be gently pulled through the nose by the string which has been kept in front and in the inferior meatus, the oily injection having lubricated the parts. At least ten or fifteen minutes should be taken to remove the plug. In case the plug is not easily dislodged, which is very seldom, it may be pushed back into the nasopharynx, first having additional string tied to the string already in place. The plug may be then removed by the forceps or drawn down and coughed out by the patient himself. This method cannot be used in cases of great obstruction in the nostrils and in that case he introduces a soft rubber catheter with a string at its end, catching the catheter in the nasopharynx and drawing it out through the mouth. Then a pledget of cotton is tied to the string and pulled through the posterior nares, the nostril being packed with gauze as well as cotton. In cases of deflected septums occluding the anterior nares, a piece of cotton may be tied to a string, pushed back of the palate and placed in the posterior nares with the finger. He has never seen this complication, but it may occur.—*The Journal*.

**Mark Twain and "Christian Science."** Mark Twain has tried "Christian Science" and tells us all about his experience, in the October *Cosmopolitan*. He was in Bavaria, or in some other foreign out-of-the-way place, and in an unlucky moment fell from a high precipice, broke forty or fifty bones, and dislocated most of the joints of his body. No physician was to be had within miles, but a horse doctor, and a "lady doctor" from Boston, who was a follower of Mother Eddy. He did not like to try the horse doctor, so he tried the "Christian Scientists," and he tells us how he tried to understand the occult reasoning of Mrs. Fuller—that's her name—from Boston. When he complained of the pain he was told: "Matter has no existence; nothing exists but mind; the mind can not feel pain, it can only imagine it." "But it hurts, just the same," exclaimed Mark, as the dislocated joints and the broken bones got in their work. "It doesn't," remarked Sister Fuller, and she immediately proceeded to show the inconsistency of pain, the

reasoning and wherefores of the explanations befuddling the patient considerably. Just as he was most bewildered, the Stubbenmadchen accidentally stepped on the cat's tail, and the cat let fly a volley of cat profanity. Mark, with hesitancy, asked: "Is a cat's opinion about pain valuable?" "A cat has no opinion; opinions proceed from mind only; the lower animals being eternally perishable, have not been granted mind; without mind opinion is impossible." "Then she had a *real* pain." "I have already told you that there is no such *thing* as *real* pain." "It is strange and interesting. I do wonder what was the matter with the cat," Mark soliloquised. After more interesting philosophic conversation, in which the cat was the central thought, Mark was instructed in the grand principles of "Christian Science." "The fundamental propositions of 'Christian Science' are summarized in the four following self-evident propositions: 1. God is all in all. 2. God is good, Good is mind. 3. God, spirit, being all, nothing is matter. 4. Life, God, omnipotent good, deny death, evil, sin, disease. There—now you see." But he could not see, and had the "fundamental propositions" worked backward without effect. Nevertheless, the "Christian Scientist" fixed him up all right. The bones slipped into place, the broken ends got together, and everything was lovely as far as the fractures and dislocations were concerned. But he had a cold and a stomach-ache, and as Mrs. Fuller could not manage these, he was finally compelled to call the horse doctor, who relieved him after giving a few buckets of bran mash. Mark treats the subject in his usual manner. Part of the time he employs sarcasm, then a little of that innocent philosophy is brought into play, and the latter has full sway when he tells about the book, the "Bible Annex," as he dubs it, which, though inspired eighteen hundred years ago, was not copyrighted till 1875, since when it has been copyrighted three times, and this he does not understand. He thinks they would get along better if they did not go so far in claiming business. "The 'Christian Scientist' was not able to cure my stomach-ache and cold; but the horse-doctor did it. This convinces me that 'Christian Science' claims too much. In my opinion it ought to let diseases alone and confine itself to surgery. There it would have everything its own way. The horse-doctor charged me thirty kreutzers, and I paid him; in fact, I doubled it and gave him a shilling. Mrs. Fuller brought in an itemized bill for a crate of broken bones, mended in two hundred and thirty four places—one dollar per fracture. 'Nothing exists but Mind?' 'Nothing,' she answered, 'all else is imaginary.' I gave her an im-



aginary check and now she is suing me for substantial dollars. It looks inconsistent."—*Journal A. M. A.*

**The Fee of the Doctor.** When we are ill the fastest automobile seems to move like a snail in bringing the doctor to us. We are apt to exclaim that we "would give almost anything" for the doctor to come quickly. His coming is a most welcome presence, and as he alleviates our own pain, or the ills of those we love, we speak of him in unmeasured tones of gratitude. There seems no man for whom we would do quite so much as we would do for him: no one who so thoroughly has our gratitude in his keeping. This is when we are ill, or in the first days of recovery. But some weeks or months after we are well, and when we have almost forgotten how close we were to death's door, and how skillfully the doctor snatched us out of the very jaws of death, the doctor's bill come along. And somehow our ardor has cooled; we have forgotten the gratitude which swelled within us—and we let the doctor wait.

For it is an amazing fact that of all bills sent to a family, that of the doctor is in hundreds of families the last one to be paid; and in more cases than it is pleasant to contemplate, it is never paid at all. I have recently gone to the trouble to make some inquiries into this matter, and have been astounded to find that not one-fourth of the bills sent by doctors are paid with anything like promptness. Answers to inquiries addressed to a large number of physicians in all parts of the country showed further that the actual collection of fees was so lamentably small that the facts, if printed in statistics, would scarcely be credited. For instance, one computation showed that in the case of over three hundred physicians one-fifth of their bills were either never paid or were compromised. Yet in all these cases I was careful to consult physicians whose fees were exceedingly moderate, and whose patients were principally those who could easily afford to pay their doctors' bills. In fact, poor people settle their physicians' bills more promptly than do people of large incomes. It was actually surprising to find how many people seemed to have absolutely no sense of duty in this matter. The bills of dressmakers, florists, confectioners, haberdashers—all were paid before the doctor's turn came. In almost all cases the doctor's bill was paid last.

It is the more difficult to understand this singular negligence, or reluctance, to meet promptly the fees of doctors when one stops to think how the average physician has to work for his money. In

fact, there is no class of professional men in any walk of life which is harder worked than are physicians. Their skill and knowledge, first of all, are required at a loss of time and money inconceivable except to those who know something of the life of a medical student. When a young doctor hangs out his shingle he has to wait for years before anything like a lucrative practice comes to him. His years of young manhood are practically wasted, for it is with difficulty that a young doctor obtains the confidence of the community in which he is located. And when his practice comes, what does it mean to him? A life spent at the beck and call of any one, at all hours of the day and night, in heat or cold, in rain or shine. No matter how miserable he may feel, he must rise, if he can, and try to alleviate the ill or ail of some one who very often is not half so sick as he is himself. His life is spent in rooms of suffering. He leads, in other words, a dog's life—and worse, because he often goes out in weather when he feels it inhuman to take his horse or his dog. That is the successful doctor.

And yet such a man, such a factor in our lives, is allowed to wait for his fee, when he presents his bill, for weeks, and sometimes for months. I have often thought in connection with this that, perhaps, if doctors sent their bills at shorter intervals than they now do it might mean prompter payments. Except in cases of protracted illness I have never quite understood why physicians, instead of waiting three, six, and sometimes twelve months, should not adopt the commercial method of presenting monthly bills. For it is unquestionably a trait in human nature which makes it harder to pay a bill six months after services have been performed, and where in many cases those services have slipped from the mind. Be that as it may, and even if it does seem more "professional" for doctors to submit their bills at long intervals, they ought not to be the people who should be kept waiting for their money. The very fact that they already have waited three or six months should entitle their bills to first or early consideration of payment. If some families kept their groceryman or butchers waiting for the payment of their bills as they do their doctors, their credit would soon be looked into and regarded with suspicion. Surely the man who alleviates our pain, or mayhap saves us from death, is entitled to the same consideration as the man who feeds us. As I say, when we are ill, "when the devil is sick," in other words, we would do anything for the doctor: nothing would be too great for us to do for him. But when we get well, ah, then it is different. Then how true it is, when "the devil was well—the devil a monk was he," and

instead of doing everything we vowed in our illness we would do, we do nothing: we fail to show even the smallest courtesy possible by a prompt payment of our bills.

There is a quickening of the conscience: a simple realization of a proper sense of duty needed in this matter of paying the fee of the doctor. It is high time, in the case of hundreds of families, that this matter should be brought home to their sense of fairness and justice. And as with them the doctors have for so many years been the last to receive their due in the payment of their bills, it would be only simple justice that hereafter "the last shall be first." No worker in the field of human industry deserves better at the hands of the people whom he serves than the doctor, and to pay his fee promptly and cheerfully is the least we can do for the service which he gives us.—*Ladies' Home Journal*.

**Physicians and Students of Mortality Statistics** will be interested in learning of the work now being accomplished by the chief statistician of vital statistics of the United States census, by the authority of the director, Hon. William R. Merriam. It is a practical effort, necessarily of limited scope, to secure the adoption of a uniform certificate for the return of deaths and looking toward the establishment of a common national system of collection of vital statistics for the purpose, primarily, of the census tables and publications.

Correspondence has been had by the chief statistician, Mr. William A. King, with the officers in charge of mortality registration in the states employing such a system, and in the cities having a population of 5,000 and more at the last census which also collect and register death returns. Complete and accurate information of the different methods in vogue has been obtained, and it was found that there is much unnecessary and objectionable variation, considered from the census point of view, in the form of official returns.

Having no power to compel co-operative action, and hampered by want of time in which to carry out the whole project, nevertheless the census office undertook to secure the modification or amplification of the death certificates so as to have them include the items necessary to obtain census data. A model return form was prepared and submitted, with explanatory correspondence, to each registration office or officer controlling the preparation of the state or local forms.



The result has been more important and gratifying than even the census office expected, as not only have the items in the specimen form been very generally adopted, but the registration officers have abolished many practically obsolete local variations in their certificates, and the latter have been made to conform to one standard more nearly than ever before.

The promptness and willingness displayed by the state and local officers in complying with the request of the director has been surprising as well as gratifying. The benefit that will result to the census office and to science from this first step toward the goal of national uniformity is incalculable, but it will be seen readily that the study of the natural law of the growth of the population is made easier and more certain.

The director of the census confidently expects that physicians everywhere will appreciate the desirability of the new order of things, and that they will earnestly and actively co-operate in securing prompt and accurate mortality returns of the uniform character required by congress and sought for by statisticians. He recognizes the fact that failure on the part of physicians to give vitality to the common standard by carefully reporting the items that may be new to their certificate will be fatal to the end in view.

**Six Women** have so far entered the freshman class of the Johns Hopkins Medical School. There are now thirty-five women in the school, fourteen being in the graduating class, and seven so far have obtained degrees. Fifty-three new medical students have so far been enrolled, of whom eight are from Baltimore.—*Maryland Med. Journal*.

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### All's Well That Ends Well.

*Aunt Geeshaw* (of Hay Corners): "Did the story you were just readin' in the newspaper end happily, Joshua?"

*Uncle Geeshaw* (approvingly): "Gosh! Yes; the beautiful heroine got cured of an incurable disease, an' it tells the name an' price of the pills that did the trick!"—*Puck*.

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*The Doctor*: "There is nothing serious the matter with Freddy, Mrs. Blakly. I think a little soap and water will do him as much good as anything."

*Mrs. Blakly*: "Yes, doctor; an' will I give it to him before or after meals?"

## Counter-Irritants.

### To His Delinquent Patient.

If I should die to-night—

And you should come to my cold corpse and say,  
Weeping and heart-sick o'er my lifeless clay;

If I should die to-night—

And you should come in deepest grief and woe,  
And say, "Here's that \$10 that I owe,"

I might arise in my great white cravat

And say, "What's that?"

If I should die to-night—

And you should come beside my corpse to kneel,  
Clasping my bier to show the grief you feel;

I say, if I should die to-night—

And you should come to me, and there and then

Just even hint 'bout paying me that ten,

I might arise a while—but I'd drop dead again.

—*Gross Medical College Bulletin.*

### Mr. Shivvers Tries Heroic Treatment.

"Um-m-m!" said Mr. Shivvers, thoughtfully, laying down his paper. "I believe there is something in that."

"In what?" asked Mrs. Shivvers.

"Why, in their 'Health Hints for the Helpless' they say that the reaction and after-glow of cold morning baths is an infallible cure for neuralgia and rheumatism," explained Mr. Shivvers.

"Cold water right out of the spigot, without any warm water at all?" cried Mrs. Shivvers.

"Certainly replied Mr. Shivvers.

"O-o-o-oh! I couldn't," shuddered Mrs. Shivvers.

Mr. Shivvers smiled a superior smile.

"Of course it is rather heroic treatment, and requires considerable moral as well as physical courage, but to a man convinced of its efficacy that is of no consequence," he said, complacently, "and I certainly shall give it a fair trial. Besides," he continued, fortifying his sudden resolution, "it is not one sudden freezing plunge, but a gradual immersion while you very slowly count six. Like this: one, and you put in one foot; two, you put in the other; three, you sink upon one knee; four, you kneel on both; five, you plunge in your arms; and six, you immerse your body. So, after all, it is not so very dreadful. Yes, I shall certainly try it to-morrow morning."

However, Mr. Shivvers did not seem so enthusiastic in the morning. His wife let the cold water run, according to his instructions, until the tub was full to overflowing, but, in spite of reiterated information to that effect, he still lingered in bed.

"Jeremiah," cried Mrs. Shivvers at last, from the bureau, where she was doing up her hair, "this is the eleventh time I've

called you, and you just must get up. You'll be late for breakfast as it is. You needn't try that bath if you are afraid of it," she added with a laugh.

Slowly and reluctantly Mr. Shivvers crept out from under the warm covers, silently casting a look of full reproach upon his smiling spouse, and into the bath-room, with the laggard step of one who has something weighing upon his mind. Then there was a long, a very long, wait. Nor was it until his wife had several times exhorted him to "Hurry up, Jeremiah!" that she heard him say:

"O-o-o-one. \*Ouch! Gosh!"

Then there was another wait, and another exhortation.

"T-t-t-t-twoooo. Ow-ow-ow-wow!"

Another wait and exhortation.

"Th-th-th-th-three-e-e-e-e," next came chattering from the bath-room, immediately followed by a blood-curdling shout and a tremendous splash. Then there was a succession of agonized yells, and what Mrs. Shivvers at first took for a streak of lightning flashed out of the bath-room, plunged into bed, and rolled itself tightly up in the covers.

"Why, Jeremiah!" gasped Mrs. Shivvers.

"Mr. Shivvers simply glared and shivered.

"Woman," he growled, when he could control his chattering teeth, "did you leave that cake of soap in the bottom of the bathtub on purpose?"—*Harper's Bazar*.

### New Use for Whitewash.

A clergyman was walking through the outskirts of his parish one evening, when he saw one of his parishioners very busy whitewashing his cottage. The parson, pleased at these somewhat novel signs of cleanliness, called out, "Well, Jones, I see you're making your house nice and smart." With a mysterious air, Jones, who had recently taken the cottage, descended from the ladder, and slowly walked to the hedge which separated the garden from the road. "That's not 'xactly the reason why I'm adoing of this 'ere job," he whispered, "but the last two couples as lived in this 'ere cottage 'ad twins; so I says to my missus, I'll tak an' whitewash the place, so as there mayn't be no infection. Ye see, sir, as 'ow we got ten of 'em already." Whether the whitewashing was effectual or not, I have not been able to ascertain.—*Medical Standard*.

### Men of Standing.

"Who are your leading citizens here?" asked the man who was soliciting for county histories.

"Which?" asked the farmer.

"Your men of standing?"

"Oh, there's Bill Bright, Abner Bruntwistle and—and—oh, a lot more of 'em. They don't do nothin' but stand around the deepoe all day."—*Indianapolis Journal*.



# THE Cleveland Medical Gazette

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## Original Articles.

### SOME THOUGHTS ON PELVIC DISEASE IN WOMEN RESULTING FROM INJURIES DURING PARTURITION.

BY EDWARD S. STEVENS, M. D., LEBANON, OHIO.

I have had under my observation at intervals for several years past a patient the care of whose case has suggested one or two questions.

Let me first give a brief history of the case.

The patient is a young woman below the average in height, weight and endurance. She has one child, who was about four years of age when I first saw her professionally. So far as she knows her pregnancy and confinement were uneventful. About a year after the birth of her child she began to suffer with pelvic pain, and her menstrual periods became of longer duration, and the flow was more profuse. Two years or more passed, and she became pale, weak, and nervous, and the flow continued from month to month without intermission for more than three months. Her condition was such that it was not to be wondered at that at one time malignancy was suspected. Her physician detected a lacerated cervix, and advised that it be repaired. It was after this time that I first saw her.

The local conditions at the time of my first visit were as follows: The cervix was lacerated bilaterally and eroded, the uterus was retroverted and adherent, in each ovarian region was an enlarged and tender immovable body, and the endometrium was granular and bled at a touch.

It was explained to her that probably three operations would be necessary to effect a cure, the first of which would be a curetting of the uterus, the second would be for the repair of the laceration, and the third would be an abdominal section. She consented to do whatever she was asked to do. A long course of preparatory treatment, consisting for the most part of copious injections and external applications of hot water, regular attention to the condition of her bowels and internally a tonic, was followed in due course of time by the repair of the torn cervix. At the same time the uterus was curetted thoroughly. After the removal of the sutures the use of the hot water was resumed.

Her condition recently (after nearly two years) has been that of improvement in general health and strength, increase in weight, freedom from pelvic and other pains, and regularity in menstruation, although her periods are but three weeks apart. It has been explained to her that her uterus is still retroverted, and that her tubes and ovaries are bound down and sealed by the products of inflammation, but that as she does not know of this except as she is told it need not trouble her, and that she need have no further operative interference as long as she remains in her present condition of health.

One of the points suggested to me by this and some other cases that have come under my observation, was with reference to the frequency of injuries to the uterus during childbirth, and other causes of infection as determining factors in the production of pelvic inflammation, and tubo-ovarian disease. We are told by some whom we love to look upon as authorities that gonorrhoea is the chief cause of these forms of disease, and we have learned almost to think gonorrhea whenever a woman complains of ovarian discomfort. It has happened to me to see in private practice a comparatively large number of women who were made chronic invalids by ovarian and tubal disease in whom no history of gonorrhoea could be traced. In searching the histories of these women it has been found oftener than not that such disease as was present began shortly after a confinement, and sometimes a cervical laceration was discovered as the probable site of infection. Frequently the laceration has called for no operation for its repair, and general and local treatment similar to the preparatory treatment outlined in my case report has been sufficient to restore the general health. While, therefore, I recognize the fact that gonorrhoea is present oftener than we like to confess it, especially in the tubal abscess, yet I am sure that gonorrhoea is not the most

frequent cause of chronic pelvic inflammation among such women as come under my own professional care.

Is it possible that we apply sometimes too carefully the teachings of the clinic rooms for the out-door poor to the cases of persons in better moral and social surroundings? The women who attend these clinics are the comparatively poor, the pauper, and the debased. Certain diseases are more common among them than among those who are more favored in their home life and general social atmosphere.

A second matter suggesting itself is relative to conservative treatment. We are hearing a great deal of this subject at present. The papers written upon it come upon one almost as apologies for doing work about which it would seem that some question might be raised as to the propriety of doing the work at all. Who would think for a moment that it is lawful to extirpate any part of a human being, even though it be not in a perfectly normal condition, as long as there is not present a condition of health below the standard which is clearly traceable directly to the presence of such parts? Who would think for a moment that it would be proper to leave within the body such diseased organs as by their presence produce a condition of health below the standard? Who would think for a moment that it is exercising the best judgment to cut away diseased parts which lower the standard of health, if other safer means of effecting a cure be at hand which will leave the sick one more as Dame Nature intended she should be? Upon these three questions hang the gist of the matter of the conservative treatment of pelvic diseases in women.

Let me refer for a moment to the case which I have used as a text for these remarks. When I first saw this woman I believed she would not be well until her abdomen was opened and the adhesions broken up, the ovaries and tubes removed if they were in as bad a condition as they then seemed, and the uterus fixed in a more nearly natural position. Had she had pus-tubes nothing short of this line of treatment would have answered in all probability. By adopting a line of treatment essentially conservative she has escaped for the present, probably for all time, operative interference of a sort from which she probably would have recovered with her life, but which, nevertheless, is not entirely unattended with danger. It has taken a little more time, but time is not so much an object in this world as some busy people would try to make us believe. As a certain disciple of Philista has said, "You should never hurry unless you are really in haste."



## PUS IN THE PELVIS.

BY HERMAN E. HAYD, M. D., M. R. C. S., ENG., BUFFALO, N. Y.

Pus in the pelvis should be dealt with upon general surgical principles, and, like pus in any other part of the body, should be evacuated as soon as it can be certainly diagnosticated. The history of the case, the existence of a gonorrheal infection, or a mixed infection consequent upon criminal or traumatic abortion, the presence of fever and acute pain and tenderness upon vaginal and upon bimanual examination, the presence of a tender mass in the pelvis, which has perhaps existed for weeks, increased leucocytosis, after having excluded pus in other quarters of the body, is strongly presumptive of a pelvic suppuration. Fever, however, does not always exist, and, in fact, is often absent, even with large collections of pus, but when present suggests an acute element in the way of an exacerbation of old inflammatory exudates, or a recent mixed infection with the streptococcus organism in evidence.

Nature, by her beautiful protective processes, shields herself from the approach of pus by making dense barriers of adhesions, and, as a rule, confines the suppuration to certain definite areas. If it were possible to establish free drainage from below for all the different points of suppuration, it would be natural to expect that in a short time the acute trouble would subside and reparative processes begin; but, unfortunately, many of these pus cavities are lined by a secreting membrane and will continue to give off pus so long as these membranes exist *in situ*. Therefore, in many of these cases, the cure cannot be effected unless the diseased organ is eradicated, and if it is intensely bound down, irreparable injury must follow when operating through the narrow vagina and without the sense of sight to aid in peeling off the agglutinated organs. Again, operating through the vagina presupposes a diagnostic accuracy which men do not and never will possess, and when the advocates of this method divide their cases into certain classes, the one operable by one method, and the other by the other method, they make fast rules which practical everyday experience does not justify them in assuming.

Some cases are peculiarly suited for the vaginal operation and all men pretty well agree that they should only be attacked through the vagina; for instance, a pelvic abscess confined to the broad ligament, or an abscess where pus is free in the pelvis, or a large pyo-salpinx or ovarian abscess alone or with multiple ab-

scesses, which has assumed such enormous proportions that it might well be called a pelvic abscess when it exists not only above the pelvic brim but is even pointing low into the vagina.

The advocates of vaginal operations maintain that there is less shock after such operations than when the same are performed through the abdomen. I am inclined to believe with Baldy and his followers, that shock, as we ordinarily see it, is not much of a factor in producing mortality, and that when we can exclude injuries to important organs by reason of careless manipulations, when bowel and visceral tears have been properly taken care of, when unsuspected torn ureters have been properly anastomosed mere time consumed by experienced operators in their operations is not responsible for increased mortality. Hernia occurs less frequently now by reason of our improved surgical technique and perhaps not more often than the same takes place after vaginal operation.

The presence of an abdominal scar is no objection, because few women care anything about their scars if good health and function have been restored to them by reason of their operation.

It is also said that the period of confinement is much less and the convalescence much more rapid when operations are performed through the vagina. This statement also interests me but little, because I am satisfied that our patients get up altogether too soon after an operation, and assume to work in an absurdly short time. If, by reason of your special skill and experience, you are enabled to best meet this condition through the vagina, with less danger to your patient and more satisfaction to yourself, adopt that method. But first carefully consider that vaginal operations in the pelvic cavity are more difficult to perform than through an abdominal opening, that vaginal surgery is necessarily less complete and the dangers and risks of accident to important structures infinitely greater, and the possibilities and necessities for conservative surgery of the tubes and ovaries is entirely out of the question. Whether you leave the uterus in cases of double pyosalpinx or ovarian abscess, is a subject which is not yet definitely settled, but of one thing I am sure, that the consensus of best surgical thought of today is to leave the uterus when possible to support the lower abdominal segment, and to remove only such portion or portions of the ovaries and tubes as are irreparably diseased, so as to continue as long as possible the function of menstruation, which is necessary for the physical and mental well being of woman.

## Abstracts and Extracts.

### REMARKS ON THE PRESENT MILD TYPE OF SMALL-POX.\*

WM. M. WELCH, M. D., PHILADELPHIA.

Two or three years ago smallpox of mild type appeared in Southern States, variously regarded as chickenpox, impetigo contagiosa or smallpox. The disease was infectious, rarely resulted in death, seemed to attack negroes especially. After the appearance of the eruption the patients frequently did work as usual. Infection was spread to distant localities by cotton. In explanation of the mild type, it has been suggested that smallpox in the tropics is less severe than in a cold climate. Difficulty in diagnosis. The diagnosis of chickenpox was most common error next, impetigo contagiosa and "Cuban itch." Considering the rare opportunity of late years for physicians to study smallpox clinically, the young physician begins his lifework with no other knowledge of smallpox than that from books or lecture. Hospitals in which contagious and infectious diseases are treated should be opened for clinical instruction. As a rule didactic lecture treats only of typical cases, but in the hospital typical and atypical may be studied. In 5,500 cases of smallpox the author has never seen cases present, uniformly, so mild a type, nor been able to find in literature any account of a similarly mild epidemic. Eruption thickly set, even semi-confluent, particularly on the face, while in some of the mildest cases it was impossible to count a dozen pustules, writer has never seen more than two or three cases during the present prevalence which showed symptoms at all serious, there being 128 patients without a single death, 110 unvaccinated, 17 vaccinated in infancy.

The prophylactic power of vaccination is clearly evident from fact that so few cases of smallpox occurred in persons vaccinated. Even before vaccination was discovered small outbreaks with mortality of 18 per cent., while death rate during eighteenth century was 40 per cent.

Course of disease: The patient usually taken suddenly ill, chill more or less marked, pyrexia 101 deg. F. to 105 deg. F., irritability of stomach, lumbar pain, headache and high temperature with delirium, in children somnolency, convulsions often occur. The tendency to syncope, dizziness, excessive prostration,

\* Philadelphia Medical Journal, January, 11-18, 1899.



common in severe cases, absent in mild type. In mild form 48 or 72 hours from the chill to eruption, temperature at this time drops to normal, other symptoms improve. Eruption appears on face, forehead, wrists, in two or three days outbreak is complete, papules elevated, dense vesicles earlier than usual, even on second or third day of eruptive stage umbilication may be seen, but not in all. As early as fourth or fifth day vesicles change into pustules, shrinking and drying begin. Lesions are discrete, a few, however, semi-confluent. After dessication the solid part remains, giving appearance of warty excrescences; this eventually disappears. The lesions develop between outer epidermis and cells covering the papilla, the true skin is only mildly involved, hence intumescence is very mild; necrosis greatly limited, little or no pitting. In consequence of short course of pustular stage, suppurative fever is not seen in majority of cases, implication of upper air-passages not met with.

**Differential Diagnosis.** In varicella no distinct febrile stage, except a rise of temperature may precede the cutaneous manifestations by a few hours or occurs simultaneously. Lesions of varicella appear as distinct vesicles containing clear serum, first on parts covered with clothing, especially the back; successive crops vary greatly in size, unilocular, readily broken by fingernail, soft velvety to the touch, many enlarge by periphereal extension; not umbilicated, form crusts in two or four days, which are thin, brown and friable, and when fallen off and instead of pigmented spots remain, few permanent scars. Exanthem of small-pox appears as papules firm and dense like grains of sand, first on face, papules slowly develop into vesicles with turbid or milky contents, umbilicated; multilocular, epidermic covering dense on exposed parts, face, hands and arms, uniform in size, requires twelve or more days to pass, in mild cases five or six days, and leave pigmented spots and pitting.

**Impetigo contagiosa, vesico pustules.** They remain flat in comparison with conical appearance of vesicles of variola. Crusts thick, straw color to a greenish-yellow or brownish, friable and crumble.

**Pustular syphiloderm** preceded by fever, aches and pains, however, in successive crops it may be distinguished from small-pox by milder constitutional symptoms, absence of shot-like induration, vesicles at summit of papules; large indurated base; absence of umbilication; thin brown and friable scabs of coppery hue and concomitant symptoms.

F. C. H.

## TABES DORSALIS—PATHOLOGY, DIAGNOSIS AND TREATMENT.

C. L. DANA, M. D., NEW YORK.

Personal studies and experiences show tabes a systemic disease picking out certain parts of spinal cord, its roots and certain cranial nerves; not constitutional, but limited to nervous system. Effects outside are secondary. First, posterior spinal roots from posterior ganglia, part passes into posterior column; part forms sensory nerves. Spinal ganglionic cell with central and peripheral processes called sensory neuron, which is the seat of the disease. Neurons of spinal ganglia develop for touch and temperature first, for muscle, sense, equilibrium and reflexes later. Tabes is not an inflammation, or result of an inflammation, but primary atrophy, not due to syphilitic meningitis, which would not explain Argyll-Robertson pupil. It is an early senility due to congenital or acquired weakness, or to a toxine.

Statistics give seventy-five per cent. with a luetic history. Tabes not syphilis, primary, secondary nor tertiary, e. g., a man suffering from tabes in second stage had contracted a supposed primary lesion ten years before, was treated with mercury, iodide, baths and at hot springs, never had secondary or tertiary symptoms. In four or five years developed tabes.

Case of syphilo-phobia, eight years, developed tabes. Something in the system runs its course unaffected by mercury and iodide.

Is there not a by-product or double infection?

Two other factors, heredity, over-use or abuse of spinal cord. Badly developed sensory neurons in combination of infection with abuse that a tendency may be acquired.

Edinger produced lesions in rats by forcing them to exercise inordinately.

Little importance upon alcohol or cold.

Diagnosis.—Pupillary symptom is most important; with one other symptom is sufficient in ninety-five per cent.

Loss of knee jerk with one other symptom is sufficient. In ten per cent. disease has an anomalous beginning.

Rectal crises, neuralgias and parenthesisias. Neuralgic crises only. Diagnosis on pains alone.

Gastric crises.

Anthropatic type. Sudden painless swelling of knee, ankle, or easy fracture.

Optic type with manifestations of secondary syphilis.

Laryngeal crises, tickling, choking in the throat followed by spasmodic coughing.

Early symptoms are areas of anaesthesia, sensitiveness to cold with lack of sensitiveness to heat. Knee jerks absent, abdominal reflexes exaggerated.

Treatment, anti-syphilitic, tonic, thermal baths, electricity, massage, cord-stretching, spinal counter-irritation.

Hypodermic injections of corrosive sublimate 1-20 grain once or twice a day. Grains xxx of iodide of potassium daily, later 300 grains a day, if possible: continued for about four weeks.

A warm bath twice a week.

Patient receives the tonic treatment of iron, phosphoric acid, glycono-phosphate of lime or soda, grains xi, daily.

Counter-irritation to spine by the cautery. Rest as much as possible.

Fattening foods, malt, cream and oil are to be recommended.

If patient is without history of syphilis, it is purely degenerative. They must have two months' rest, tonic and bath regime. Large doses of strychnine and small of morphine by hypodermic injection, slowly increased to tolerance.

Strychnine is a useful drug, but a dangerous one.

Periodic rest and tonic treatment must be persistently kept up.

Ergot in vesical weakness. Hot baths are dangerous. Some patients are helped by electrical treatment, galvanization of the spine and general faradization. Fraenkel's method: Systematic exercise for training limbs, two or three times a day. It does not cure and is adapted in first or second stages, which have ceased progressing.

This disease begins, runs its course as though by inexorable fate.

We stand helplessly watching such cases. They belong to patients with particularly unstable neurons or infected with malignant virus.

In other cases the disease stops of its own accord. In majority balance between neuron and poison delicately adjusted.

Hence there is a field for wise therapeutics.

Pathology of tabes by Dr. William G. Spiller (*International Medical Magazine*, June, '97), Dr. Emil Redlich (*Die Pathologie*, etc., June, 1897). Reports upon exercise treatment, presented in Goldscheider's monograph (Lipzig, 1898), and by Dr. M. Allen Starr on therapeutics (Association of American Physicians, vol. xiv., 1899).

F. C. H.



## THE TRAINING OF THE PHYSICIAN.

BY DAVID STARR JORDAN.

President Leland Stanford Junior University and California Academy of Sciences in the California Medical Journal.

If our medical schools cede four years to the culture of the colleges, they have a right to ask that the colleges waste no time. The college should furnish such means of study that the student shall not go to the medical school ignorant of the use of the scalpel and the microscope. Cats are abundant and cheap. The elementary facts of anatomy can be learned from them in college far better than in the dissecting room of the special school, where advanced work should be done, instead of the bungling efforts of beginners, who do not know a vein from a tendon.

The college course should also teach the medical student the general facts and theory of chemistry and the processes of chemical manipulation. The elements of botany and of vegetable and animal physiology should be in his possession; the facts of comparative anatomy, and the great laws of life, of natural selection, heredity, variability, functional activity and response to external stimulus, which form the basis of organic evolution. He should know a bacterium when he sees it and should know how to see it. He should have heard of the correlation and conservation of forces; in short, he should know what is meant by scientific investigation, and in some degree should have caught the inspiration of it. The physician should, moreover, learn to write and speak good English. Besides this, he ought to—he *must*—read French and German. Other languages will not hurt him, nor will a knowledge of literature, philosophy or history.

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 CAUSES AND MANAGEMENT OF SLOW FIRST STAGE OF LABOR.

BY WM. GILLESPIE, M. D., CINCINNATI.

A complication of the first stage of labor which is frequently diagnosed as rigid os, and the recognition of which is of extreme importance, is a condition in which the woman cannot completely empty the bladder. I purposely refrain from using the term distended bladder, because in many of these cases the bladder is not distended, the patient retaining the power to pass urine voluntarily, but unable to completely empty it on account of pressure of

the presenting part. In a typical case of delay from this cause the woman seems to suffer excruciatingly toward the acme of each pain. There is no condition with which I am acquainted which gives the patient such an agonised countenance. On vaginal examination you may or may not find a cystocele, depending on whether you deal with a multipara or primipara, and also upon the quantity of urine retained. A most characteristic sign of this condition of the spasmodic contraction of the os uteri. The os may or may not seem rigid during the interval, but as soon as a uterine contraction comes on its edge becomes firm, and before the pain reaches its acme it contracts vigorously, in an apparent effort to stop the descent of the head upon the bladder. At the same time the external hand will notice the globular outline of the bladder above the pubes, made tense by being squeezed between the uterus and abdominal wall. The introduction of the catheter is followed instantly by a disappearance of rigidity and a complete change in the type of labor.—*Cincinnati Lancet-Clinic.*

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## GALL STONES.

HUNTER M'GUIRE.

Medical treatment is potent to prevent cholelithiasis, but powerless to dissolve the stones when once formed. The limitation of the diet, the inhibition of large quantities of water, the practice of systematic outdoor exercise and the regulation of the bowels by the use of saline cathartics will prevent the concentration and stagnation of the bile, and act as an efficient prophylactic against the formation of gall stones. But when a calculus once develops, there is no drug which has the least solvent effect upon it, and relief from the symptoms it produces will only follow its mechanical removal, either through the bile ducts by natural forces, or through an artificial opening by surgical measures.

The question of an operation in an individual case must be determined by the frequency of the attacks, the intensity of the pain, and the effect produced on the patient's mental and physical condition. If suffering is constant; if distension of the gall-bladder is plainly perceptible; if jaundice exists and persists from obstruction to the common duct; if suppuration threatens or is present, then an immediate operation is indicated.

The danger of an operation for gall-stones is about that of an operation for appendicitis. If it is done early, before adhesions

develop or pus forms, the mortality is low; if postponed until complications exist, it is high. Delay often converts a safely operable case into a practically hopeless case, and the patient dies, not on account of the operation, but despite the operation.—*Virginia Medical Semi-Monthly.*

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### MEMBRANOUS ENTERO-COLITIS.

We have before us to-day a woman past middle life who has been, she says, many months sick. And her visage bears witness to the truth of her words. Her nose is pinched, eyes sunken, her face is drawn, her color is earthy. She is anaemic (R. C. being only 2,000,000), her skin is dry, and she has cold hands and feet most of the time. She is really very ill. We have learned that she sometimes gets better for a time, but even at her best she suffers from eructations, bloatings, sinkings at the stomach, etc. Most of the time the bowels are constipated, but there are frequent diarrhoeas. There are periods of extreme pain in the bowels which are sooner or later followed by tensions and the discharge of quantities of mucus. This mucus is in long strings resembling a tape-worm. In other cases of this kind which we have seen the mucus escapes in tubes, or casts of the intestine, or in small, irregular lumps like pieces of cooked white of egg, and their extrusion is always accompanied with pain. The attack may last for a day or two, and then the patient will have a period of complete relief of the symptoms, to be followed again and again by the same symptoms in a vicious circle. A careful examination showed no trouble with lungs, heart or kidneys. This is by no means an uncommon disease in women. Constipation, in which there is a large, hard accumulation of feces in the hepatic, splenic and at the sigmoid flexures, is I think the most common cause. Worms, microbic infection and bad alimentation are potent causes. They produce congestion, and serum and mucus are formed, the first causing the diarrhoea, the second being discharged, as described above, or covering the scybala and mixed with the feces. The condition resembles dysentery as far as tenesmus and mucus discharges are concerned, but it lacks the fever and bloody discharges.

What causes this cachexia? The answer is, fecal poisoning. The bowels contain at all times, even in health, toxins which are formed by microbic action upon the contents of the bowels. We have learned from the experiments of many observers that much



of the product of these microbes is destroyed by the cells of the liver, and that the aromatic products, cresol, phenol, etc., which are produced in the intestines during digestion, neutralise a part.

But a condition of disease has arisen in the intestines. They are denuded of their epithelium. This epithelium has a twofold action: First. As has long been known, it acts as a protective covering—a fence which shuts out from the body cavity noxious agents. Second. And this fact is not so generally known, the epithelial cells destroy the toxins in their own bodies, exercising a phagocytic action.

Charrin and Cassin have shown that the epithelia not only oppose the absorption of poisons, they absorb them and render them harmless. "A cubic centimeter of toxine placed in the blood kills in twenty-four hours, placed in the ileum forty are without effect." A definite quantity of a toxine placed in a loop of intestine curetted and closed at both ends kills promptly, while the same quantity placed in a sound intestine has no effect. Lastly, they showed that when the epithelia were removed by scraping and mixed with sterilized water containing the toxine, they attenuated its power. We believe this explains the cachexia from which this woman suffers. It is said by these experimenters that there is in some of these cases a mucus-producing bacillus. How shall we treat these cases? As it is an infection with or without a mechanical injury, antiseptics are indicated. After emptying the bowels with castor oil we will give a capsule of beta naphthol ( $7\frac{1}{2}$  grains) every four hours until the patient shows an improvement. Put a flannel bandage around her belly to support the intestines and feed purees, soups, custards and pappy foods. Let this be followed by fish, scraped beef, etc. Sometimes I think I have derived benefit from the use of dilute hydro-chloric acid and strychnine three times daily in as large doses as the patient can safely take.

# THE Cleveland Medical Gazette

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## Editorial.

### PRIZES FOR ORIGINAL ARTICLES.

In order to encourage the preparation of meritorious original matter for the medical press the GAZETTE will distribute three prizes. These prizes will be bestowed at the end of the GAZETTE's fifteenth year, which began with the November number, 1899, and will end with the October number, 1900. The first prize will consist of three fine new medical volumes.

This prize will be given to the writer of the best original article written for the GAZETTE during the year. The second prize will consist of two volumes, and will be given to the writer of the second best article; and the third prize will be one volume, given to the writer of the third best article, written for the GA-

ZETTE during this year of its publication. The prizes will all be valuable books, recently published, and very desirable additions to any physician's library. It will not be necessary to state that an article is sent in competition for a prize, unless the writer so desires. Nor will the names of contestants or winners be published without their consent. All communications to the GAZETTE during this year will be compared, and the prizes bestowed upon the three best articles judged upon the following points:

Originality in thoughts or facts presented. Value and interest to medical readers. Literary or artistic merit in the presentation of the subject.

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### THE PRINCIPAL LESSON OF THE SMALL-POX EPIDEMIC.

The recent experience with small-pox in this city has of course given new evidence of the value of vaccination as a means of prevention. One would suppose that the evidence piled up in its favor during the past one hundred years ought to be enough to convince the world, beyond the shadow of a question. But since there yet remain a few persons who are not quite convinced, we will go on piling up evidence still higher. If they yet remain unconverted, small-pox itself may be trusted to take care of their cases, as it did at Gloucester a few years ago, and in time through the survival of the fittest, those incapable of being taught will become extinct.

Then there are questions in regard to the public care of various cases, the right of the law to interfere with individual liberty, the methods, proper rules for notification, for quarantine, for disinfection, for the use of public conveyances, the liability of the public treasury for necessary expenses incurred on account of small-pox cases, and in the destruction of infected property. All these problems and more, besides the treatment, receive a new consideration during an epidemic of the disease. But there is a lesson still more elementary and important which it would seem should be learned from recent experiences: Namely, that the diagnosis of variola is none too familiar to all the members of the profession. This fact sticks out too plainly to be denied, and it is not very flattering to us either. It does not depend upon the ignorance of the people nor upon the lack of understanding on the part of the lawmakers. There is no way to shift the blame onto



somebody else. There is some excuse in the fact that through the efforts of the profession small-pox has become a comparatively rare disease and therefore unfamiliar. It is also true that the disease is sometimes atypical, or modified by vaccination, or presents peculiarities that render it difficult of diagnosis. It may be stated also as a mitigating circumstance, that the patient and his friends, through dread of the pesthouse, will sometimes use every endeavor to mislead the practitioner. They may not call him in the developing stage when the characteristics of the disease are apparent. They may deny certain points in the history of the case, as the time since the skin lesion appeared, or the pain, or a known exposure.

But all these excuses do not avail to cover the fact that the profession is not as familiar as it should be with the various manifestations of variola. When one or two or half a dozen doctors declare a case is small-pox and another number with equal positiveness declare it is not, somebody is wrong. When a doctor or several doctors allow a case of small-pox to pass unrecognized or even unsuspected, it is time there was a pulling down of text books and a posting up on diagnosis. It would be a good time for teachers of medicine to take their classes, under proper precautions, to see cases of small-pox and make the students familiar with the tactics of this wily old enemy. Many practitioners never saw a case of this disease, and students go out never expecting to see it. Perhaps they never will. Yet they may, all unexpectedly, encounter it at any time; and the greatest lesson to be learned by the profession of Cleveland during our recent experience is that it will not do for physicians to be either ignorant, rusty, or careless upon the subject of small-pox. KELLEY.

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## PUBLIC PLAY GROUNDS, GYMNASIA AND BATHS FOR THE CHILDREN OF CLEVELAND.

These are subjects which should interest physicians and upon which the medical profession should have an opinion, and be ready to give its advice and influence at the opportune time. No one knows better than the physician the relationship between a sound physical organization and a sound mind, and none have so strenuously insisted upon hygiene in our schools, and the necessity of physical training not only as a means of health and development, but as an important part of education. The open

air play-ground with simple gymnastic apparatus and baths as accessories, are as obviously desirable as is the exercise; and in a perfect system of education they are as essential as a school house with seats and desks. In the country districts and in towns the play-grounds are ample, and with pure air and a cleaner soil and fewer dangers to life and limb the children of average homes stand a better chance to develop normally, and safely reach adult life. In large and crowded cities these conditions are quite different. The school yards are cramped and there are no fields or woods nearby to which the children may resort. In the densely populated sections to be out of doors at all they must play in the streets and take their chances amidst dust or mud laden with filth, street cars, wagons, bicycles. Of course there are many sections of our city in which the private grounds are ample for air space and play-room. It is a curious fact, however, that in these sections there are fewer children to enjoy the advantages. We are fond of calling Cleveland a city of homes and saying that it is spread abroad like a great country town, and so a part of it is. But this does not alter the fact that there are other parts densely populated, one section containing twenty-five thousand people within a space a half-mile square, six thousand of these being children. No citizen can be blind to the recent rapid construction of flats or apartment houses; or can have failed to notice that they allow no adequate vacant ground in proportion to the number of persons they propose to shelter; or but knows that this means a denser crowding of the population.

These flats have been so far of the better sort—what might be called very genteel tenement houses—some of them even assuming to be “very swell” albeit “altars of gab” as they have been termed by one who knows them well as a social institution, but loves them not. But one need claim no great gift of prophecy to predict that the “apartment house” will soon be followed by the “tenement”—the same thing on a cheap plan—and that Cleveland’s days of spreading out are now to be followed by days of filling up until the population per square mile in some sections will be dense enough to nearly smother the old-time citizen who explores around in this “city of homes.” What has all this to do with play-grounds for children? Merely this, that if we are ever going to make an effort to get them, now is the accepted time. In the year 1898 the city of New York paid \$3,000,000 for a children’s play-ground. It wouldn’t have cost that much if it had been purchased when New York was no older than Cleveland is;

and it would have been worth millions to the children all these years. The longer such things are postponed the harder they are to accomplish. Witness the endless delay in the extension of Bank street, and in the straightening of an elbow of another street, crooked and malodorous literally and politically. We are getting a magnificent system of parks, but the very people who most need them and would be the most benefited by them will seldom reach them. If one of those parks could be cut up in blocks and distributed at intervals through the crowded section of the city it would do infinitely more good. Not that we would like to see such spaces devoted to hot houses or flower beds, or warnings to "keep off the grass." They should be prepared and used as public play-grounds, supplied with simple gymnastic apparatus and baths, under the charge of a caretaker. In Boston a system of public play-grounds is under the management of the park commissioners. A similar plan of public play-grounds, baths and gymnasiums is followed by Philadelphia, New York and Providence.

Earnest workers interested in the health and education of children have been quietly preparing the way, and soon Cleveland will be called upon to take up this problem in earnest. We hope that Cleveland physicians will be found unanimously in favor of these means of promoting health and physical development.

KELLEY.

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### AS IT SHOULD BE.

At the present time when there is an agitation for an interstate Medical Registration it may be of interest to note what our brethren across the line are doing in the matter of interprovincial medical registration. The following is taken from an article in a Toronto daily of a few weeks ago. The article refers to the proposed bill to establish interprovincial medical registration:

"The scheme of the bill is that provision be made for the examination by the dominion Medical Council of candidates desiring a license to practice anywhere in Canada. This, if arranged, will in no way interfere with the autonomy of the existing provincial councils.

"The Dominion Council will consist of delegates from the provincial councils and the amalgamation will do away with the evil which now exists of Ontario practitioners being unable to



practice in Quebec, or any other province, and vice versa. The bill will be retroactive.

"All members of the medical profession of ten years' standing or over will be immediately licensed to practice anywhere in Canada without special examination. Those of less than ten years' standing will be at liberty to take the examination for such a license. The aim of the bill will be to establish a system applicable to Canada generally, with the ultimate hope of bringing about an imperial medical council, providing a license to practice anywhere in the empire."

With the passing of such a bill the medical profession of the Dominion may breathe easier. The system of State registration with us and Provincial registration in Canada in vogue at the present time is really more absurd than the tariff system. The tariff can be satisfied by a monetary consideration, but not so with many of the States and not at all with the Provinces. How is this local registration going to affect a practitioner who, after several years' practice and because of failing health or other causes, must remove to another State or Province for the sake of the climate to be obtained? It may be that the desired location is in a State which demands an examination. To say truth, we must admit that an examination to many of us is, at any time, rather embarrassing, and probably more so if it must be tried in failing health and when slightly unprepared for it. It is certainly better that the present narrow sphere of local registration should be broadened out so as to extend from ocean to ocean, for that is as it should be.

LAUDER.

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### ONE WAY OF WRITING MEDICAL ESSAYS.

Too many medical articles written nowadays neither contain a new idea nor yet an old idea presented in a new way. In too many of them the ideas are borrowed from previous writers and even less forcibly and attractively presented than they were in the original. A writer may quote extensively and credit his authority. Sometimes he may abstract and credit his authority. Either of these methods is at least legitimate, often useful and may be even admirable when properly used. But some writers borrow ideas without giving credit; either in presenting the ideas in their own language or merely paraphrasing. This, of course, when presented as the writer's own is dishonorable. Occasionally we find a writer borrowing ideas, arrangement, language and all, and

presenting them as his own, and this is despicable. We could present examples of all these varieties of literary methods, and without going very far into ancient literature to do it, either. But there lies before us a specimen so choice that we cannot forbear presenting it to the readers of the GAZETTE.

A literary production has been circulated in the city bearing the heading "The Proof of Cure of Gonorrhea" with the name of a Cleveland doctor appearing in due form as the author. This essay would reflect credit upon the Cleveland author, as he doubtless intended it should, but for one fact, namely: the only part of it that is of any value is taken bodily from an article written by Ferd. C. Valentine, M. D., Professor of Genito-Urinary Diseases in the New York School of Clinical Medicine, and published in the *Clinical Recorder*. The Cleveland writer not only does not mention Dr. Valentine's name; nor even make use of quotation marks to distinguish the extracts he has so freely transferred; but before introducing them he distinctly remarks upon "the trouble to which I have gone in formulating these facts."

Lest we be accused of injustice in these statements we will here reproduce the papers so presented that the reader may see for himself. Here is the Cleveland doctor's introduction, which for aught we know is an original composition upon old ideas:

"In my opinion there is no subject the importance of which is so underestimated by the profession as that of the evil after effects of Gonorrhea. There is no subject of equal importance that has been given so little careful and thorough study with a view to obtaining full and correct statistics.

"Perhaps on account of my practice being confined exclusively to diseases of the urinary and sexual organs, this matter may strike me much more forcibly than it does the average physician who sees a case only from time to time. Nevertheless, if I lead such physicians to study their cases more carefully, or if I can get them into the frame of mind to impress upon these few cases the very grave nature of the so-called simple Gonorrhœa and the necessity for watching the patient carefully for years afterward, as well as prohibiting intercourse entirely with the wife so long as a single germ exists, I shall feel that I have in a measure been compensated for the trouble to which I have gone in formulating these facts, will have been enlightening my fellowmen and possibly be the means of saving thousands of pure wives and innocent children from the evil results of a foolish husband and father's ignorance or carelessness."

Here the Cleveland author begins to introduce Dr. Valentine's article, but without quotation marks, and the only change we have discovered in this first extract, with the two papers lying side by side before us, is that in the first sentence what the Cleveland author designates as gonorrhœa, Dr. Valentine's original paper called clap, and the addition of the word "and," both of which changes we have placed in Roman letters. All that appears here placed in italics was borrowed from Dr. Valentine:

*Ordinarily when the discharge ceases a patient considers that he has recovered from gonorrhœa. The physician, however, knows the tendency it has to persist, even after all external manifestations have passed off.*

*Unfortunate experience has shown that months or even years later the apparently cured patient really has residual (often called latent) gonorrhœa. The danger of such a condition merits more care in dismissing a case than the average patient likes or understands. The trouble and physical disturbance to which he is put fail to appeal to him, and unless it is made plain that he may harbor a continuing menace to himself and others until positive proof that nothing of his gonorrhœa remains, is obtained.*

*The methods for securing this end are in the main simple and easy of execution. An attempt will here be made to describe them. In doing so attention will be called to the possible errors in employing these tests.*

*Stripping the urethra.*—The manner in which patients endeavor to show that no discharge is expressible (i. e. squeezing the penis) is, from the anatomical nature of the organ, no proof at all. The proper and only efficacious manner of stripping the anterior urethra is accomplished thus:

1. Rest the four left fingers upon the left corpus cavernosum and the left thumb upon the right corpus.
2. Bend the right index finger and press it against the penoscrotal angle until it is pushed as far as the lower margin of the arch of the pubis. Firmly pressing the urethra, as this finger is drawn forward, it will carry to the meatus any discharge or excess of moisture that may be so obtainable. Not infrequently a large yellow drop, replete with gonococci, can be thus brought to view long after the discharge has ceased.

*Possible Errors.*—The drop or excess of moisture may not be obtainable by stripping, if the patient has recently urinated, and in many cases cannot be produced unless the examination is



made in the morning, the patient not having urinated since the night before.

When for any reason this cannot be done, the patient should be given several cover glasses, and instructed to catch a small particle of the morning drop upon one and press another upon it. In this manner it can be brought to the office for examination.

But all discharges are by no means gonorrheal. The absence of gonococci in the drop would, after repeated microscopic examinations, show that the patient has merely a urethrorrhea, which often requires no treatment except as far as its depressing influence upon the patient is concerned.

*The Urine.*—Generally 50 cubic centigrams of the first urine passed suffice to wash out the anterior urethra. Whenever possible this examination should be made early in the morning. The most convenient manner of obtaining the separate urines and one that suffices for ordinary office work, is to have the patient half fill a 12-inch ignition tube, and then urinate into a second one.

If both urines are clear, it is generally accepted that the urethra is normal.

*Possible Errors.*—On centrifuging clear urine a deposit may be obtained. If not, a few drops of alcohol added to the specimens will, on second centrifuging, throw down a slight deposit. In case this deposit, microscopically examined, shows thinned epithelium with very faint or no nuclei, the patient should be warned that an infiltration is at least beginning, and that he must be at once treated by dilatations, lest he become a victim to stricture and all that it portends.

*Filaments, Flakes, etc., in the urine,* if very thin, white, and transparent, if they rise to the top of the column of urine, if they float near the center, if they dissolve soon, and if the microscope shows them to be composed only of mucus, some epithelial scales and perhaps a few non-pathogenic microbes, are entirely harmless. If they lack in any of these characteristics they show a diseased process going on, which must be elicited and properly treated.

Here the Cleveland author omits a paragraph of Dr. Valentine's paper which for the sake of completeness we will introduce in quotation marks in our ordinary type. It is as follows:

"*Ramonage.*—The great master Guyon, suggests this method of obtaining specimens from the deeper urethra for microscopic examinations. It consists in anointing with glycerin as large a *bougie-a-boule* as can be easily introduced. Immediately upon its

withdrawal from the urethra, the substances that adhere, especially to its shoulder, must be removed for examination. This search for disease-products can be well associated with examination by the same instrument for stricture etc."

After this slight omission the Cleveland author's paper proceeds as below, which is the same, word for word, as Dr. Valentine's paper with the exception that in the paragraph on "*Silver or Bichlorid Test*" the Cleveland man has introduced the word "microscopical" in front of the word "examination."

*Residual Posterior Gonorrhoea may exist without any or with exceedingly slight disturbance. A somewhat cumbersome, but exceedingly good, manner of eliciting its presence is performed as follows:*

1. *Wash the anterior urethra with boric acid, four per cent., by means of a soft catheter, or preferably by irrigation as far as the compressor, without a catheter, until the fluid that escapes from the meatus is entirely clear of granules.*

2. *The 100 cubic centimeters of urine then passed through the cleansed anterior urethra will contain so much of the secretions of the posterior urethra as can be detached by the force of the stream.*

*The urine so obtained being clear, by no means assures the patient of freedom from posterior urethritis. Other methods are still required.*

*Expression Urine.*—After obtaining the first and second portion of urine, the posterior urethra may be expressed in the following manner:

*The patient is laid on the table; the index finger, well ointed with vaselin, is inserted, and avoiding the prostate, the pulp of the finger presses the posterior urethra by stroking it firmly from above downward against the pubis. The urine which accumulates during this process will then contain as much evidence of disease as can be expressed from the posterior urethra.*

*Infection of the Prostate and Seminal Vesicles.*—This is determined by massage of these organs in the same manner as above described. Massage of the prostate is easy enough, even for the beginner; stripping the seminal vesicles, however, requires some experience. In disease of the adnexa, their massage is frequently followed by a discharge from the urethra of their contents.

*Possible Errors.*—These three processes should not be performed at the same time, lest confusion in diagnosis result. An interval of a day or two should be allowed the patient, who would

be made, to say the least, very uncomfortable if obliged to submit to three such examinations in immediate succession.

*Beer Test.*—It is a good rule to cause patients, a week after all discharge has ceased, to drink, on retiring, double the quantity of beer or champagne to which they have been accustomed. This is likely to produce a discharge, if a residuum of the disease exists.

*Silver or Bichlorid Test.*—An irrigation of the urethra with nitrate of silver, one per cent, or corrosive sublimate, 1-5000, usually suffices to set up a urethral discharge, lasting from eight to thirty-six hours.

The microscopical examination of this discharge will reveal the presence or absence of gonococci. If the beer test and silver test yield no results, the patient is advised to employ the

*Condom Test.*—This consists in telling the patient to use a condom at his next sexual intercourse, and to bring it with its contents for microscopic examination. It is most likely to contain not only semen, the secretion of the urethral mucosa and its glands, but also any bacteria that the reproductive apparatus may harbor. Naturally, their location cannot so be determined, but their presence assured.

The Cleveland essayist here omits Dr. Valentine's section on the preparation of a specimen for the microscope which we here reproduce:

*Preparation of a Specimen for the Microscope.*—For the convenience of those who are not obliged to daily use the instrument, I repeat the method of preparing specimens, which serves all purposes:

1. Spread the discharge, filament, or sediment as thinly as possible over the cover-glass.

2. Let it dry under a bell-glass, to protect it from dust or air-microbes. This usually requires about three minutes.

3. Pass it three times through the opened Bunsen-flame, with an even motion, to "fix" it.

4. Drop eosin (saturated solution in alcohol) upon the cover-glass and hold it over the closed Bunsen-jet until a slight, visible evaporation results.

5. Hold it under a stream of water until all the eosin that can be washed away is carried off. If the cover-glass stood on edge, over filter-paper gives it ever so slight a tinge, the washing has been insufficient, and must be repeated until nothing but clear water comes from the glass.



6. Drop two per cent. methylene-blue upon the glass and let it rest so, covered for five minutes.

7. Wash as described under No. 5, and mount for examination.

The remainder of Dr. Valentine's paper, omitting the foot notes, is as follows:

"Physicians who cannot devote the ten or twelve minutes to this preparation of a slide, will do well to merely take the specimen on a cover-glass, place another cover-glass upon it, and send the specimen to a colleague or a bacteriological laboratory for examination.

"All the preceding tests are within the power of the general practitioner. To, however, positively establish the termination of a case, to be able to assure a patient contemplating marriage,

"The Urethroscope Is Required. Until a more easily manageable instrument is devised, I continue to use Oberlaender's urethroscope. The best instrument employing projected light is the Otis aëro-urethroscope which, however, as it expands the urethra, make errors possible by obliterating the normal folds during examination.

"As urethroscopy is required for the *finesses* of diagnosis, the instruments merit discussion only in a paper prepared for genito-urinary specialists."

And here is the remainder of the brilliant effort of the Cleveland writer: The reader may make his own comparison:

*Physicians who cannot devote fifteen to thirty minutes to a microscopical examination, will do well to merely take the specimen on a cover-glass, place another cover-glass upon it, and send the specimen to a colleague for examination.*

*All the preceding tests are within the power of the general practitioner. To, however, positively establish the termination of a case, to be able to assure a patient contemplating marriage, the urethroscope is required.*

Men oftentimes will consult physicians on the propriety of marriage. Such a case may have had gonorrhoea some years before, and wishes to know if he may consider himself perfectly cured. On examination neither secretion nor hiaments nor gonococci may be found, and still the man may not be cured, as is shown by a case narrated by Oberlaender, of Dresden:

"A physician, who had his last attack of gonorrhoea six years previously, called on Oberlaender on account of a bladder weakness. He had recovered quickly and

apparently entirely from his previous gonorrhoea. He had had no discharge or any other symptoms for five years. About four years before he had an attack of rheumatism, followed by almost annual recurrences. He was married about three years ago. His wife aborted in the fifth month of pregnancy; this was followed by gonorrhoeal endometritis. Then the patient began to experience vesical weakness. The urethroscope revealed indisputable chronic urethritis. Appropriate treatment caused the urethritis to subside; the rheumatic attacks ceased and the bladder symptoms disappeared."

I may add here a case of my own. One of my patients consulted me not long ago regarding a peculiar twisting of the urinal stream, which he attributed to a possible stricture. Nine years before he had gonorrhoea, of which he considered himself perfectly cured, as he never had any symptoms thereof since. At the time of the consultation the possibility of a fresh infection was out of question.

Superficial examination showed no discharge, few filaments only, no gonococci; a large-sized sound passed the urethra easily. The urethroscope showed some infiltration of the urethra and several diseased glands. I succeeded in removing a little secretion from one of these glands. To my great surprise it revealed gonococci.

Such cases will occasionally occur. In view of such facts alone, even entirely by themselves, ay, without resorting to analogies of any kind, must a specialist, and especially the urologist, not be required to employ all available diagnostic means? What would be thought of a physician if he limited his examination of a case of tuberculosis to what bacteriology of the sputum revealed, without inquiring into the pathological changes of the lungs by percussion and auscultation?

If we further remember the fearful havoc gonorrhoea exerts in women as well as in men, can it be permissible to neglect even one means of confirming the diagnosis? These points alone demonstrate beyond all and any peradventure that urethroscopy is necessary.

Further comment upon this case seems hardly necessary. We may pay our compliments to other original productions of Cleveland some of these days.

KELLEY.

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#### KOPLIK'S OR FLINDT'S SIGN.

Dr. Koplik, the well-known New York pediatricist, between the years of 1896-1898 and under the title of "A New Diagnostic Sign of Measles," called attention and claimed originality for the

discovery of an early manifestation of the morbillous exanthem. His writings upon the subject have been very extensively copied to the extent that in Germany it is now known as the "Koplik-fruh symptom," but it appears that he was not the original discoverer of this important and early sign of measles.

In a recent number of the *Wiener klinische Wochenschrift*, Dr. Siegfried Weiss calls attention to the fact that in 1896 Professor von Jurgensen in a contribution upon measles contained in Nothnagle's great work, has quoted a description of this early symptom of measles from an original article published by Flindt, a Danish physician. A description given by M. Flindt in the *Sundhedsschollegiets Aarsberetning* for 1880, seems to be more accurate than that given by Koplik.

Quoting from Weiss' translation of the original Danish: "*Second day of fever:* A spotted exanthema may be seen on the anterior surface of the soft palate, and on the mucous membrane of cheeks and lips. This shows quite a remarkable appearance due to the numerous minute, bluish-white, shining, and apparently vesicular points which lie in the center of small, red spots, and are arranged in irregular groups. One can feel, as well as see, the small vesicles projecting out above their surroundings. A similar miliary formation is to be seen on the palpebral conjunctiva.

*Third day of fever:* Similarly grouped spots with vesicles are visible on the buccal mucous membrane, especially on that part of it lying opposite the space between the upper and lower back teeth. At this stage the skin eruption first makes its appearance.

It seems from this that Koplik was not the first to discover this interesting and important symptom of the most common of the exanthema. It also teaches us the important lesson of using great care in claiming originality until we have carefully examined the records of all nations. It does seem a little peculiar that Dr. Koplik failed to examine Nothnagle's great work before making the claim of priority. But since we are made aware, by Dr. Weiss' translation of Flindt's original article with incontestible proof of its publication, we have naught else to do but to give the Dane his due, sorry as we are to rob Dr. Koplik of a discovery which we believe so far as he is concerned is absolutely original.

ALDRICH.



The American is a chronic medicine-taker. He must have his nerve sedative, his stomach pill, his rheumatism eradicator, his liver stimulator, besides the hundred and one things, patented and otherwise, for the exclusive use of his wife and daughter. He takes his medicine to make him well, if sick; to keep him well, if not. This propensity of his has built up cities like Lowell, noted more for its patent medicine factories than any other industry; and the names of families who have made their wealth by catering to the fancied ailments of their countrymen are prominent beyond others in New England cities.

\* \* \* \* \*

The patent medicine business was a weakling at its birth. But it soon grew sturdy and strong, notwithstanding the pompous and energetic condemnation given it by the physician. In fact, the more the physician condemned it, the more it seemed to grow, until, realizing the little progress made, he contented himself with smiling in a superior and lofty manner whenever the subject was mentioned. But the almighty dollar invested in the powerful newspaper continued to educate the public concerning the efficiency of Skinem's pain dispeller and others of its kind, and the physician's opinion became a minus quantity.

\* \* \* \* \*

But of late years the patent medicine man despised not the opinion of the physician. With the craft of an Ulysses he decided to make the physician instrumental in placing his medicine on the market. He advertised his produce largely through the medical journals, sent samples to his doctor friend, urged him to use it in his practice, and to make a show of being ethical, printed the constituents upon the label. And the physician dutifully prescribed it, sent his patients to the drug store for it, and wrote the manufacturer a cute little testimonial concerning it. So when the manufacturer had worked the medical profession he advertised it largely in the all-powerful newspaper, and the patient of the physician who prescribed it, recommended it to all his friends as a very good thing, because his family physician had ordered it for him. And Tongaline and Wine of Cardui and others were made moneymakers for the genial patent medicine man.

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Moral? Oh, there is none! It's the same old tale of confidence in anything that comes along on the part of the physician. He forgets that he can write a prescription for the same thing

which can be put up in the average drug store as good and palatable as in the manufacturer's laboratory, at a much cheaper price. In the dim and misty future when the physician will be educated in business principles, he will overcome these things. But it won't happen in the life of the present generation, so don't let us worry.

## Periscope.

*Physiology of Pregnancy.* ALBERT CHARRIN and GUILLÉMONAT (*Compt. rend.* 1899, 1180).—Inanition in pregnant guinea pigs was compared with that in normal animals. In all cases, a few c. c. of a saline solution were injected daily under the skin. The pregnant animals waste more rapidly, excrete less urine and less urea, develop less heat, are poorer in iron, and offer more marked alterations of structure than the others.

*Iron in the Spleen During Pregnancy.* ALBERT CHARRIN (*Compt. rend.*, 1899, 1614).—The determinations of iron in the spleen confirm the fact, previously recorded by others, that during pregnancy the iron diminishes in that organ, and passes to the foetus. Microchemic examination confirms this result.

*Influence of the Grape Cure on Human Metabolism.* B. LAQUER (*Chem. Centr.* 1899, 893).—During the grape cure, there is proteid-sparing, and in consequence, a putting on of proteid. The aromatic substances contained in grapes which are not too sour produce a lessening of uric acid, and cause it to be separated in a relatively soluble form; this depends on the relationship between the mono and di-sodium phosphates. Hippuric acid is not markedly influenced. Large quantities (4-5 pounds) of grape juice increase proteid putrefaction, and cause a rise in the ethereal sulphuric acids of the urine.

*Metabolism in Inanition.* FREDERICK N. SCHULZ (*Pflueger's Archiv*, 1899, 379).—During inanition, or when the nutriment given is insufficient, as when carbohydrate alone is given, there is, on the day or two preceding death, an increase in the nitrogen excreted in the urine. This rise, which has been noted by previous observers, is usually accompanied with albuminuria; the nitrogen of the albumin is not, however, sufficient to account for the total increase of nitrogen, but it probably is an indication of the breakdown of the kidney cells. The experiments recorded on rabbits and dogs show that this ante-mortem rise of nitrogen

is not a criterion that the animal has reached an absolute minimum of fat, although probably the fat which is left is, in the condition of the animal, not capable of proper utilization.

*Intestinal Absorption.* E. WAYMOUTH REID (*Proc. Roy. Soc.*, 1899, 94).—The physiologic activity of the intestinal epithelium in absorption is demonstrated by the absorption by an animal of its own serum or plasma under conditions in which filtration, osmosis, and absorption are excluded; and by the cessation or lessening of the absorption when the epithelium is removed or injured, in spite of the fact that facilities for osmosis and filtration are thereby increased. The chief factor in the absorption of pepton is assimilation (or absorption) by the cells, whereas in the absorption of sugar, diffusion, variable by the permeability of the cells (and so probably related to their physiologic condition), is the main factor. Alcohol stimulates the cells, bile does not. Details are added which show differences in different parts of the intestinal canal. The cells take up organic solids most slowly, then water, then inorganic salts. SPENZER.

## New Books.

**ELECTRO-HAEMOSTASIS IN OPERATIVE SURGERY.** By Alexander J. C. Skene, M. D., LL. D., Professor of Gynecology in the Long Island College Hospital, Brooklyn, N. Y.; formerly Professor of Gynecology in the New York Post-Graduate School; Gynecologist to the Long Island College Hospital; President of the American Gynecological Society, 1887; Corresponding Member of the British, Boston and Detroit Gynecological Societies, of the Royal Society of Medical and Natural Sciences of Brussels, of the Obstetrical and Gynecological Society of Paris, and of the Leipzig Obstetrical Society; Fellow of the New York Academy of Medicine; ex-President of the Medical Society of the County of Kings; ex-President of the New York Obstetrical Society. Published by D. Appleton & Co., New York.

This very valuable contribution of Dr. Skene's to the literature of electro-haemostasis in surgery deserves especial mention and commendation. This practically new field in the domain of surgery has been treated in a most concise and thorough manner. Every surgeon should be familiar with the work, and we would heartily recommend it to every medical man as a valuable addition to medical literature.

C.G. FOOTE.



**A TEXT-BOOK OF MATERIA MEDICA, THERAPEUTICS, AND PHARMACOLOGY.**

By George Frank Butler, Ph.G., M. D., Professor of Materia Medica and Clinical Medicine in the College of Physicians and Surgeons, Medical Department of the University of Illinois; Professor of General Medicine and Diseases of the Digestive System, Chicago Clinical School; Attending Physician to Cook County Hospital; Member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society, Chicago Pathological Society, and Chicago Society of Internal Medicine; Fellow of the Chicago Academy of Medicine, etc. Third Edition, Thoroughly Revised. Philadelphia. W. B. Saunders, 925 Walnut Street. 1899.

A well written and carefully arranged work, broad in its scope, and up-to-date in every particular. It is divided into several sections: Pharmacology and General Therapeutics; Pharmaceutical Preparations; Disease Medicines; Symptom Medicines; and Topical Remedies. There is also a chapter on prescriptions and prescription writing which, in common with the others, is one of extreme excellence. Altogether the work is one of the most complete we have seen upon the subject.

G. S. S.

**A MANUAL OF THE DIAGNOSIS AND TREATMENT OF THE DISEASES OF**

**THE EYE.** By Edward Jackson, A. M., M. D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic; Formerly Chairman of Section on Ophthalmology of the American Medical Association; Member of the American Ophthalmological Society; Fellow and ex-President of the American Academy of Medicine. With 178 Illustrations and 2 colored Plates. Price \$2.50. W. B. Saunders, 925 Walnut St., Philadelphia.

This book of 604 pages, fresh from the press, embraces all that is new in the science of ophthalmology. The author is a well-known worker and writer. As stated in the preface, "This book is intended to meet the needs of the general practitioner of medicine and the beginner in ophthalmology." As such the book cannot be better described. The author's good judgment and advice is shown in his expression of opinion with regard to removal of those eyes which are liable to become "exciting eyes." This is a question upon which authorities have different opinions. The author states as follows:

"A. If blind from injury and the seat of iridocyclitis. (1) When known or supposed to contain a foreign body which cannot be extracted. (2) When the injury has occurred in the ciliary region. (3) If the injury be recent (within two years) and the

patient cannot remain within easy reach of competent professional advice, even though the eye does not contain a foreign body, and the wound was not in the ciliary region.

"B. If not blind, but with greatly impaired vision and the seat of iridocyclitis. (1) If known to contain a foreign body that cannot otherwise be removed. (2) If the wound be in the ciliary region, and the inflammatory process be active with diminished intra-ocular tension.

"C. If the eye has been so severely injured that all chances of further useful vision is destroyed, even though inflammation has not yet set in, it should be removed if the patient cannot remain under competent observation."

Two chapters—17, "Mechanical Injuries of the Eye and its Appendages," and—18, "Remedies and Their Applications," will be of advantage in many cases for ready reference. Chapter 20, "Ocular Symptoms and Lesions Connected with General Disease," is one that will be appreciated by the general practitioner. The colored plates and illustrations are good. LAUDER.

ESSENTIALS OF MEDICAL CHEMISTRY, ORGANIC AND INORGANIC, ETC.  
Prepared especially for Students of Medicine, by Lawrence Wolff. Fifth Edition, revised by Smith Ely Jelliffe. W. B. Saunders, Philadelphia, 1899.

A Question-Compend containing a systematically arranged list of questions with answers of that part of physics and chemistry which more immediately concerns the physician and medical student. The volume is well and very satisfactorily arranged and is quite sure to continue in favor. SPENZER.

A LABORATORY MANUAL OF PHYSIOLOGICAL CHEMISTRY. By Elbert W. Rockwood, B. S., M. D., Professor of Chemistry and Toxicology in the University of Iowa. Illustrated with one Colored Plate and three Plates of Microscopic Preparations.  $5\frac{3}{8} \times 7\frac{3}{4}$  inches. Pages viii-204. Extra Cloth, \$1.00 net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia.

This small volume is a careful step-like compilation of experimental exercises in medical chemistry, concise and well written. Certainly anyone with manipulative skill and faithful consideration of the text cannot help but acquire numerous important and useful medical-chemical facts.

The subject matter offers information even to the advanced student and in extent and character is among the very best of its kind, and can be heartily recommended to student and practitioner alike for accuracy and merit.

Finally, we are grateful to Dr. Rockwood for his happy thoughts and to the publishers for their efforts in producing so excellent an American treatise.

SPENZER.

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THE BULLETIN OF THE OHIO HOSPITAL FOR EPILEPTICS. Vol. I, Nos. 2 and 3. July and December. 1898. Published by the Hospital at Gallipolis, Ohio. Price, this number, \$1.00.

A little more than two years ago a pathological laboratory was established in connection with the Ohio Hospital for Epileptics. Dr. A. P. Ohlmacher was secured as director of this laboratory, which, under his able management, has become one of the best equipped research laboratories in the country. He has prosecuted investigations in the pathology of epilepsy with his well-known enthusiasm, obtaining results of the greatest importance and blazing the way into an almost unlimited field for original research. The records of his work, together with other papers on epilepsy, have been published in the Bulletin of the Ohio Hospital for Epileptics. The typographical work of this number of the Bulletin is of a high grade, and with the seven heliotype and half-tone plates from original photographs, makes it a very handsome publication of 236 closely printed pages. The contents are as follows:

An analysis of the statistics of the hospital since its opening, November 30, 1893. H. C. Rutter.

Studies in the Pathology of Epilepsy, A. P. Ohlmacher.

I. A General Survey of Twenty-five Cases of Epilepsy examined post-mortem.

II. The Anatomical Evidences of the Lymphatic Constitution in Idiopathic Epilepsy presented by Five Additional Cases including One of Status Epilepticus.

III. A Case of Secondary Epilepsy with Hematomyelia, Multiple Cavernoma, Psammoma, and Osteoma in the Central Nervous System.

IV. Two Examples of Cerebral Neurogliomata producing Secondary Epilepsy.

V. A Case of Epileptic Idiocy and One of Imbecility in which Peculiar Trophic Conditions were found.



Several Examples Illustrating the Comparative Pathology of Tumors, A. P. Ohlmacher.

In the first article Dr. H. C. Rutter, manager of the hospital, gives a complete and interesting analysis of the statistics of the institution since its opening. One thousand two hundred and eighty-five patients have been admitted, and four hundred and seventy-three discharged; 13 per cent. of those discharged were considered cured, having had no return of the disease in two years; 38 per cent. improved and 22 per cent. unimproved. The mental condition of 45 per cent. was abnormal. Suicidal tendencies are rare. The ranks of epileptics are largely recruited from the lower walks of life, the factors favoring its development in infancy being present to a much greater extent among the very poor and shiftless of a community. The tendency in nearly all cases has been toward mental degeneracy. Epilepsy invades all homes, but selects the greater number of its subjects from the environment of want, ignorance and vice. Under the general title, "Studies in the Pathology of Epilepsy," Ohlmacher in his first article gives a general survey of twenty-five cases of epilepsy examined post-mortem. In his introduction the author emphasizes the necessity of careful accumulation of morbid anatomical data, not only concerning the central nervous system, *but of the body at large*, while at the same time applying the methods of careful bacteriological scrutiny. As a consequence of such work this laboratory contains not only the records of the immediate examinations, but also the gross specimens, the microscopic specimens, bacteriological preparations, etc., properly preserved and classified in keeping with recorded notes, made upon cards, somewhat after the card catalogue system. The immense value of such a collection of material can be best appreciated by those engaged in pathological work. A brief consideration of the technique employed in this study is given, following which is the account of the individual cases, many of these being given in abstract. This general review especially emphasizes the remarkable variation in the cases sent to the hospital as epileptics, there being examples both of genuine *grand mal*, and of several kinds of secondary epilepsy.

The second paper upon the lymphatic constitution in idiopathic epilepsy is without doubt the most interesting of the series. Three well-marked examples of the lymphatic constitution in the first six cases presenting themselves at autopsy were met with and reported in the *Bulletin* issued in January, 1898. The oc-

currence of a persistent thymus, of general lymphatic hyperplasia, and the other conditions pertaining to the *constitutio lymphatica* in these three cases was looked upon as more than an accident, as much support to these views was derived from a study of the pathological and clinical features of other conditions associated with thymic hyperplasia, whose analogy with epilepsy it was attempted to prove. The testimony of these first three cases no longer stands unsupported, as five typical additional cases were found in which genuine *grand mal* was associated with the lymphatic constitution.

After a careful and full detailed description of each case the author passes in final review the most prominent features of the five cases, it being his hope to make the case for the lymphatic constitution in genuine *grand mal* so clear on morbid anatomical grounds that this phase of the subject need not be again discussed. Of these five cases there were three males and two females, four of them in the third decade of life when death came, and one just entering upon the period of adolescence. All were afflicted with idiopathic *grand mal*, this neurosis appearing in infancy or childhood. The women were also subject to periodic epileptic mania. One of the men was in a state of beginning dementia, the other was sane, but dull and slow, while the third had not yet suffered mental derangements. From the anthropometric standpoint all exhibited the external evidences of the lymphatic constitution. Coming to the mode of death all these five individuals died suddenly, meeting death directly or indirectly as the result of *grand mal* attacks. A state of lowered resistance seems to be one further factor to be considered. This characteristic of the lymphatic constitution as attested by recorded cases of thymic asthma and thymic sudden death. It seems justifiable to describe *grand mal* as a "temporary death of all save the vital functions." Accidents which would be entirely insufficient under other conditions become fatal to the victim of *grand mal*.

In all these cases the subcutaneous fat was more than shown by a healthy person of the same size and weight. This is also true of the fat in the retroperitoneal layers, the mesentery, omentum, and mediastinum. The most striking element in all these cases was the *persistent and enlarged thymus* which in its well-nourished macroscopic condition and typical histology could only be classed as a persistent lymphoid thymus. It is not possible from these morphological grounds to conjecture whether the organ was endowed with normal or abnormal functional activity.

Next in importance comes the general lymphadenoid hyperplasia affecting principally the lymphoid follicles of the digestive tract and those of the spleen. Then of the arterial hypoplasia there is abundant proof. After removal of the heart, the aortas of these five individuals measured relatively a third less in circumference than those of a normal individual of the same age, sex, height and weight. Further proof of the true relationship of the condition under discussion with *constitutio lymphatica* is furnished by the evidences of *old rachitis* in three of the five cases, one as scoliosis and two as well marked pigeon-breast. In four of the five cases the thyroid showed alterations of one kind or another.

Ohlmacher here takes up a consideration of *rachitis*, *eclampsia of infancy*, *laryngismus stridulus*, *tetany* and *grand mal*, reviewing the literature, and suggesting an association of epilepsy in the same category on morbid anatomical grounds, as has already been foreshadowed by certain clinicians. In conclusion he says, the purpose of this contribution is to supplement the previously published reports from this laboratory along the same trend, and in combination with them to offer such testimony as to convince the most skeptical critic that *the morbid anatomy of the lymphatic constitution is associated with idiopathic grand mal in the majority, if not all the cases which exhibit the typical characteristics of this form of epilepsy*. The fundamental object of the investigation was the discovery of a morphologic basis to serve as a rational foundation upon which to build future studies along the clinical, histological, experimental and therapeutic lines. That this is an important step in advance will be keenly appreciated when we recall the entire absence of any uniform data relating to a sound anatomical groundwork for *grand mal*. In a condensed form the most important points in this communication are offered as follows:

I. Five additional cases of genuine *grand mal* present prominent evidences of the lymphatic constitution.

II. These five cases include the most typical examples of idiopathic epilepsy out of nineteen epileptics examined post-mortem.

III. All these five cases met death suddenly in a condition of good general nutrition, hence, presumably the well-marked features of the *constitutio lymphatica*.

IV. The remaining fourteen cases include examples of (a) secondary epilepsy, epileptiform convulsions of idiocy, of infantile paralysis, etc., not to be included with primary *grand mal*,



and (b) of genuine epileptic insanity with death after gradual wasting, where, presumably, the once present adenopathies of the lymphatic dyscrasia have atrophied and disappeared.

V. A persistent thymus with all the histological characteristics of lymphoid activity in the most prominent anomaly, which is accompanied by a general lymphadenoid hyperplasia and arterial hypoplasia.

VI. Three cases show osseous deformities of old rachitis, and indications of thyroid disease appear in four.

VII. *From both morphological and physiological grounds a relationship is suggested between genuine epilepsy and rachitis, eclampsia infantilis, thymic asthma, thymic sudden death, tetany and (possibly) exophthalmic goitre.*

The two following articles in Ohlmacher's "studies" show the same evidences of painstaking, thorough work, and appeal especially to students of neuropathology, while the concluding article describes some rare and interesting examples of tumors in the lower animals.

This publication is most creditable to the hospital—to its trustees and manager, who established this laboratory for the purpose of utilizing its material for scientific purposes. It places both the medical profession at large and the public of the State of Ohio under obligation, and deserves only the heartiest support at the hands of both.

SCHNEE.

## Notes and Comments.

**Dr. George Seeley Smith** has removed his office to 122 Euclid avenue.

**Dr. and Mrs. Hunter Robb** spent Christmas at the doctor's home in Burlington, N. J.

**Dr. W. H. Nevison** is spending the winter in Arizona in the recuperation of his health.

**Dr. Calvin Shaw** has moved from 106 Wade Park avenue to the new apartments at the corner of Willson and Payne avenues

**Dr. H. A. Becker** has given up his office on Prospect street and is now located on the corner of Pearl street and Clark avenue.

**Dr. Manley H. Simons**, Medical Inspector U. S. navy, who is temporarily on duty in this city at the Naval Recruiting Station, is at The Garlock.

**Drs. D. D. McCallum and J. B. Moses**, of Crestline, were in the city on Dec. 11th and 12th. They were witnesses in a suit for damages against a railway.

**Dr. Robert H. Martin**, of Cedar avenue, was operated on for appendicitis on Nov. 8th. The doctor went through three attacks before deciding to undergo the operation.

**Dr. A. J. Ochsner**, of Chicago, was in Cleveland the latter part of November and attended the Cleveland Medical Society meeting of Nov. 24th. He was the guest of Dr. Hunter Robb.

**Dr. Nicholas Senn**, of Chicago, addressed the Cleveland Medical Society Friday evening, December 22d, the subject being fractures of the skull. On Saturday morning he gave a clinic at the Cleveland General Hospital.

**Dr. N. Stone Scott**, who has suffered from chronic appendicitis for a number of years, finally decided to submit to operation on Dec. 9th. Dr. Crile did the operation, making a small incision, and the patient was visiting his down-town friends six days after.

**Among those from out of town** who attended Dr. Senn's lecture the following were noticed: Dr. Thomas H. Brannan, of Canal Dover; Drs. Wm. E. Hart, O. T. Maynard, Chas. H. Cushing, of Elyria; Dr. John A. Dickson, of Ashtabula; Drs. James Fraunfelter, E. J. March, A. B. Walker, F. E. Young, of Canton; Drs. Irving C. Rankin, E. O. Leberman, E. A. Montenyohl, Dell S. Bowman, of Akron; Dr. N. S. Everhard, of Wadsworth, and Dr. F. J. Bauer, of Mogadore. A number of the doctors remained for the clinic on Saturday morning.

**The January (1900) number of The Alienist and Neurologist** contains: "Outline of Psychiatry in Clinical Lectures," by C. Wernicke, M. D.; "Samuel Henderson, Murderer: Responsible or Irresponsible?" by Martin W. Barr, M. D.; "Transitory Mental Disorder in Hemisrania, by Prof. v. Krafft-Ebing; "Epilepsy Modified by Treatment and Environment, with Some Notes of Two Hundred Cases, by Martin W. Barr, M. D.; "Hungry Evil in Epileptics," by Ch. Fere, M. D.; "The Legal Disabilities of Natural Children, Justified Biologically and Historically," by E. C. Spitzka, M. D.; "Research in Comparative Cytology on the Nervous System of the Vertebrates, by Giuseppe Levi, M. D., besides the usual selections, editorials, reviews, reprints, book notices, etc.

## Among Our Exchanges.

**Syphilitic Iritis.** The chief symptoms are (1) ciliary congestion with a certain amount of pain referred to the forehead or temple, photophobia, and lacrymation; (2) discolored iris, sluggish action of the pupil, which dilates irregularly under atropine; (3) adhesions to the lens, deposit of uveal pigment, nodules of lymph in or on the iris.—*Jonathan Hutchinson, Jr., Medical Record.*

**Cure for Opium Habit.** The opium habit prevails among Europeans in the East to an extent which is appreciated only by those who are brought into contact with its victims. In view of this fact the announcement by McLeod, of Shanghai, that it is possible to cure the habit by the admission of sodium bromide, is indeed welcome news. He gives the drug in two doses of two drachms, in solution, every two hours for the first two days, and one drachm on the third day. Two ounces in all will probably suffice in most cases.—*Medical Times.*

**The Death-Dealing Long-Tube Nursing Bottle.** The object of this paper is briefly to give the perilous and untrustworthy features of the so-called long-tube nursing bottle, and to show justification for not only interdicting it, but doing so by law. The peculiar features of the danger from its employment may be summarily stated, that owing to its construction and material and to the use to which it is put, probably no better incubator of pernicious micro-organisms and their toxins could be easily designed, as none have proven so successful. A series of investigations was made, microscopically, bacteriologically and chemically, establishing beyond question the danger of these tubes for the introduction of pathogenic microbes into the infantile economy.—*E. Wende, Medical Review.*

**Dr. Burton K. Chance** reported (by invitation) The Ocular Findings in the Study of 23 Cases of Epidemic Cerebrospinal Meningitis. In a systematic study of the eyes of twenty-three persons suffering from epidemic meningitis the author noted among the early symptoms lessening of central vision, photophobia, burning and itching of the lids, with catarrh; in one case there had been diplopia, in another deep orbital pains followed by ptosis and facial paralysis of the left side. The visual testings yielded normal acuity in several cases despite the intense congestion of the fundus; in others there was marked diminution when the optic disks showed decided neuritis. Disturbances of the conjunctiva were seen to be localized and unilateral, and doubt-



less were due to contamination from outside sources. Abnormal convergence of both eyes was seen in two cases. There was more and greater variation in the size of the pupillary areas than would ordinarily be noted among the same number of healthy individuals. No case presented inflammation of cornea or iris or alteration in the transparency of the lens, nor were gross acute changes of the choroid or retina observed. The optic disks presented the greatest changes. Here was seen early progressive neuritis marked by hyperemia, edema, and projection forward of the disk with constriction of the afferent and efferent vessels. — *From Reports of Section of Ophthalmology, College of Physicians of Philadelphia.*

**Does It Pay?** In the course of his professional life many a man must pause and ask himself this question. In the *Cincinnati Lancet-Clinic* of September 9, there are two communications, one entitled "Does the Practice of Medicine Pay?" in which the writer, Dr. Monroe of Louisville, takes a rather pessimistic view, dwells upon the many hardships of a doctor's life, and dismisses the subject with these words: "Therefore, taking everything into consideration, I think I am perfectly safe in saying, in closing this paper, that it does not pay, financially, to be a physician."

The second paper had for its caption, "Does It Pay to Live?" in which the intellectual pleasures constituting

"The soul's calm sunshine and the heartfelt joy" are dwelt upon, and it is pointed out that there are other objects in life beside and beyond those associated with finance.

This writer, Dr. Woodruff, believes that no greater reward can come to a physician than the ability to look back upon time well spent and the consciousness of good example stamped upon the community. He says: "The opportunities of relieving suffering and inspiring hope in the despondent are so numerous in the daily rounds of a doctor, that any physician who has spent his life in the conscientious discharge of his duties, may answer the question in the affirmative."

But, after all, it is the individual point of view. "As a man thinketh in his heart, so he is."—*New York Medical Record.*

**How to Cure Worry.** Many persons would be only too glad to hear a cure for worry. The *Piccadilly Magazine* has a contributor who professes to have solved the problem, and gives the remedy, which is as follows: "The psychological basis is what is known as the law of attention, the physiological basis is in the

undoubted control of the body by the mind through the nervous system. This is the formula: When the symptoms of worry begin to manifest themselves, when your mind gets to dwelling upon some one troubling matter with feverish insistence, when you find yourself depressed or irritable or overstrung, or full of foreboding, then go into your room and lock the door. For the first application of this prescription you must be absolutely alone and in silence. After a while you may be able to make these conditions for yourself anywhere, by the complete withdrawal of your mind even in the midst of a crowd; but at first you must be quite alone. Loosen your garments completely; lie down in the most restful position you can assume; avoid raising the head too high, thus cramping the neck and impeding circulation. Now close your eyes for a few minutes, and raising the arms let them fall and lie loosely and naturally above your head. Lie thus for a minute or two, and then begin to take deep, long breaths, as deeply as possible, exhaling quietly and naturally. Keep this up for five minutes, until you are sensible of a real relaxation and refreshment of the body. You will then be in the physical condition to take up the mental work which you need to do."

**Dr. W. E. Norris** presented a case of Chancre of the Lower Eyelid. M. S., æt. 45, presented himself at the dispensary of the hospital of the University of Pennsylvania on October 20, 1899. The patient states that the disease started two days before as a little white blister about one-quarter inch from the external canthus of the right eye. When first seen there was marked swelling of the lids, with an indurated lump in the margin of the lower lid near the external canthus, about 1 cm. in diameter, yellowish in color. The bulbar conjunctiva was markedly chemosed and there was a slight conjunctival secretion. The patient had severe nocturnal pain in the forehead and temple. There are no posterior synechiæ or other evidences of inflammation of the iris. He was ordered a solution of atropia and 10 grs. of potassium iodid, the dose to be increased 2 gr. daily. Four days later the face, lids and glands of the neck were much indurated and swollen; the yellow lump on the lower lid had broken down, leaving an irregular open sore and ectropion of the lower lid. The severe symptoms gradually subsided, and on the 27th there was no pain, and the swelling of the lids and the chemosis had decreased. The upper margin of the cornea was the seat of several small superficial ulcers. Holocain was applied to the ulcers and

the sore on the lid was touched with 5 per cent. solution of protargol, later with mercuric bichlorid 1:500. On November 1st there was an indurated sore with a sharp-cut excavation. The two water-color drawings by Miss Washington give a truer reproduction of the above described state of affairs than any word painting. The patient has progressed steadily, and now, November 21st, the inflammation has subsided, the ulcer is nearly filled, and there are three minute elevations on the margin of the lid just beyond the outer edge of the ulcer. There is no history of infection to be obtained, no lesion or scar on the penis, and no symptoms of secondary syphilis. The patient attributes the lesion to traumatism, and says that some days before the above symptoms appeared the lid was penetrated by a splinter of glass that was removed by a fellow-workman.—*From Reports of Section of Ophthalmology, College of Physicians of Philadelphia.*

### **The Physician's Probation.**

O, the long and dreary waiting!  
O, the doctor's tedious waiting!  
Ever thicker, thicker, thicker,  
Grew the gloom within his dwelling.  
Ever deeper, deeper, deeper,  
Plunged his hands in empty pockets—  
Plunged his restless hands and clenched them  
At the inconsiderate village.  
Hardly from his scanty earnings  
Could the doctor pay his rental.  
With his instruments in order  
Vainly waited he the wounded.  
Scattered cards and hung out shingles,  
Prayed for patients, but they came not.  
From the suffering came no summons.  
Into fits of melancholy  
Fell and could not rise from weakness—  
Pondered thus, in savage musings:—  
O, the impotence of knowledge!  
O, the quack's cheap-bought successes!  
O, the people's blasted folly!  
O, the irony of fortune!  
All around the sick are dying,  
Victims clearly of malpractice,  
While, in philanthropic spirit,



I am dying to restore them.  
But they *will not*. Let them suffer.  
Thus he chafed and fumed and fretted  
'Till the air was blue around him,  
'Till his faith and clothes grew threadbare.  
Then there came a crucial moment,  
But he faltered not nor blundered.  
Found himself with glory covered,  
And the long probation ended.

—*A Doctor's Wife, in Medical Standard.*

**Teaching Surgery with the Cinematograph.** "Medical literature has been loaded, little by little, with useless discussions and insufficient descriptions that make it impossible for us to appreciate new methods at their proper value. Even surgeons who are able to travel and visit the principal centers of learning, can not always profit by their experience as they might desire to do.

"The unfavorable conditions in which persons who witness a great operation are situated, do not enable more than fifteen or twenty of them to follow with profit the technical details that are of chief interest to them.

"It is necessary for the security of the patient to place the spectators at a distance of at least two meters—six and one-half feet; the hands of the surgeon and assistants hide a part of the field of view, and the most delicate manœuvres can be seen only by the operator himself.

"Finally, it is not sufficient, if we wish to understand an operatory process, to see the operation performed by a surgeon who has studied under the originator of the process; we must be present at one or several operations performed by the practitioner who has devised the technical details; in a word, we must see the master himself. The surgeon is judged by his work, and the best illustrated publications can not reproduce the personality of the operator, which is his most important quality.

"It is with the aim of filling this regrettable need in surgical instruction that I have studied the question of cinematographical reproduction."

The first demonstration of the teaching of surgery with the cinematograph was made before the members of the British Medical Association at their Edinburgh meeting, July, 1898. This demonstration, says Dr. Doyen, was conclusive, and the new

method met with the approval of all the physicians present. Since this first demonstration he has made many others successfully at other scientific gatherings. There has just been announced, moreover, the establishment, under the Paris Faculty of Medicine, of a course in technical operative surgery with cinematographical illustrations. This course is not under Dr. Doyen's superintendence, but is to be managed by other surgeons who claim priority in the application of his idea. This claim he indignantly repudiates, and the customary contest will doubtless enliven French medical circles for some time to come. At any rate, the method seems to have come to stay. Some of the benefits that will result from its adoption, according to the writer, are the ease with which students in far-off countries can familiarize themselves with the practice of the masters of surgical science; the possibility of preserving the films indefinitely as records, forming a pictorial history of surgery; the information that surgeons can derive regarding their own operations, enabling them to correct errors and improve methods; and the possibility of giving the interested public, whom it would be injudicious to admit to the operation itself, general ideas on the subject of surgical procedure.—*Literary Digest*, November 25, 1899.

## Counter-Irritants.

### Posthumous Diplopia.

There was a young doctor of Cork,  
Who used to eat corn meal and pork,  
But now he cuts muscles,  
And hurries and hustles,  
And eats pie with a gold-plated fork.

He looks quite euphoric and wise,  
Makes big mon. by the traffic he plies;  
He cures epilepsy,  
The piles and dyspepsy,  
By carpenter work—on the eyes.

But when all is over and done,  
The devil will have his own fun!  
He'll make him see double—  
Two cauldrons a-bubble—  
Two hells where there is but one!

—*Philadelphia Medical Journal.*

### A Case of Misplaced Confidence.

A physician describes a remarkable case of a patient's confidence in his medical adviser: "While I was a student in the medical college, I had a patient, an Irishman, with a broken leg. When the plaster bandage was removed, and a lighter one put in its place, I noticed that one of the pins went in with great difficulty; and I could not understand it. A week afterward, what was my astonishment to find that the pin had been run through the skin twice instead of through the cloth 'Why, Pat,' said I, 'didn't you know that pin was sticking in you?' 'To be sure I did,' replied Pat. 'But I thought you knowed your business, so I hilt me tongue.'"—*Collier's Weekly.*

### The Worst of the Lot.

Mr. F. M. Holland, in his pamphlet on "Atheists and Agnostics," relates a story of a sexton who, when the rector asked why a rich parishioner had stopped coming to church, and whether the trouble was Latitudinarianism, answered: "No, sir! It's wusser nor that!" "The nit must be Unitarianism?" "No, sir; wusser nor that!" "Ah! Perhaps it is Agnosticism?" "Oh, no, sir! It's wusser nor that!" "But it can't be Atheism?" "No, sir! It's wusser nor that!" "But there can't be anything worse than Atheism." "Oh, yes, sir! It's rheumatism."



An old librarian, unable to find his umbrella one evening when it was time to close, returned, and looked anxiously for it in the card catalogue, under the letter U.

*Teacher*: "What happens when a man's temperature goes down as far as it can go?"

*Smart Scholar*: "He has cold feet, ma'am."

A woman whose doctor asked after her health replied dolefully: "I feel very well; but I always feel bad when I feel well, because I know I'm going to feel worse afterward."

*The Bore*: "I assure you, madam, that my dear friend here and I are two souls with but a single thought."

*The Lady*: "Indeed! And which of you has possession of the thought to-day?"

*Ethel*: "Mamma, what makes the ladies of the hospital all dress in black?"

*Mamma*: "Because they are Sisters of Charity, dear."

*Ethel*: "Is charity dead, then?"

"Mamma, what's twins?" asked the smallest child. "I know," replied the older one, before the mother could answer. "Twins is two babies just the same age. Three babies are triplets, four are quadrupeds, and five are centipedes."

*The Fond Mother*: "Everybody says he is such a pretty baby! I'm sure the poet was right when he said that 'heaven lies about us in our infancy.'"

*The Doctor* (unfeelingly): "But he should have added, 'So does everybody else.'"—*Life*.

Chappie had just returned from a visit to England. "Now, my dear boy," said his friend, who met him at the pier, "keep your mouth shut. Don't say a word to the custom house people." "Fawncy now!" said Chappie. "And why, me deah fellah?" "Because they'll make you pay duty on that new English accent of yours." "Quite so!" said Chappie. And he smuggled it in.

While escorting a lady home the other evening, a popular doctor attempted to relieve her cough by giving her a lozenge. He told her to allow it to dissolve in her mouth. No relief was experienced. The doctor felt chagrined the next day when the lady sent him a coat button, with a note saying that he must have given her the wrong kind of lozenge, and that he might need this one.

Beecher and Ingersoll were always good friends. Mr. Beecher had a celestial globe in his study, a present from some manufacturer. On it was an excellent representation of the constellations and stars which compose them. Ingersoll was delighted with the globe. He examined it closely, and turned it round and round. "It's just what I wanted," he said; "who made it?" "Who made it?" repeated Beecher; "who made this globe? Oh, nobody, Colonel; it just happened!"—*Indianapolis Journal*.

### The Modern "Personal."

"A rich young merchant is looking for an intelligent lady with good health as a companion for life. Replies addressed to B—— will only be taken notice of if accompanied by a portrait, an X-ray photo, and a photo of the interior of the stomach."—*Amer. Druggist*.

### Different.

*Doctor*: "Why, my man, you'll get well. When I was your age, I was just as low as you are now and with this same trouble, and pulled through."

*Patient*: "Yes, but you didn't have the same doctor."—*Ex*.

### A Physician's Certificate.

At the Dublin City sessions one morning a juror prayed to be excused, and said he had a doctor's certificate that he was not fit to serve. He handed up a closed envelope to the Recorder, who found it contained a letter from a well-known Dublin medical man. Amid great laughter in court, the Recorder read this letter aloud: "This man has been asking for a certificate that he is unable to serve as a juror. I don't know whether he is a knave or a fool, but he has little brains, and he reeks of porter."

## Publishers' Department.

GEN. LEW WALLACE, soldier, diplomat, and author of "Ben Hur," has all modern dictionaries, but consults the International twenty times to the others once. He says:

"I have on my desk all the great English dictionaries of modern issue. Speaking safely, I consult my Webster twenty times where I consult the others or either of them once."—*Lew Wallace, Crawfordsville, Ind., Dec. 9. 1895.*

President L. Clark Seelye, D. D., of Smith College, likes the International better the longer he uses it, and knows no work which can take its place.

The longer I use Webster's International Dictionary the better I like it. It is abreast of modern scholarship, and I know no work which can take its place.—*L. Clark Seelye, Northampton, Mass., Sept. 15, 1896.*

Published by G. & C. Merriam Co., Springfield, Mass.



THE CATARRHAL DIATHESS.—In catarrhal affections of the various mucous membranes, particularly of the respiratory tract, there exists not only a relaxed atonic condition of these structures but an underlying constitutional state of malnutrition. All authorities agree that in order to eradicate the local pathologic conditions, treatment by appropriate systematic remedies is indispensable; the patient's nutrition must be fostered and restored so that a degree of constitutional vigor is attained which antagonizes the catarrhal processes. Gray's Glycerine Tonic Comp. is the remedy par excellence in these cases because it has a two-fold action. Primarily and chiefly it overcomes malnutrition; it re-establishes normal nutrition by eradicating the ever-present atonic condition of the digestive organs, thus assuring the maintenance of normal digestion and assimilation of food; restoration of tone and nervous force to the entire system, and incidentally to the mucous membrane, is a natural sequence. Gray's Glycerine Tonic Comp. has, moreover, a direct local anti-phlogistic and tonic influence upon the disordered circulation of the mucous membranes; it relieves engorgement and restores tone to the relaxed atonic blood vessels. This remedy will prove effective in obstinate and recurrent catarrhal affections of the respiratory and gastro-intestinal tracts which have resisted all other treatment.



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## Original Articles.

### OBSERVATIONS ON ABDOMINAL SECTIONS BASED ON FOUR HUNDRED OPERATIONS.

BY GEORGE W. CRILE, M. D.

Professor of Clinical Surgery and Applied Anatomy, Cleveland College of  
Physicians and Surgeons; Surgeon to St. Alexis and  
Cleveland General Hospitals.

It is not intended in this paper to enter into a full discussion of any of the phases of abdominal section, but merely to make some observations of a practical nature. In this series of cases many different methods in the various parts of the technique were employed and the clinical point of view has been altered from time to time by the varying results obtained.

*On the Preliminary Preparation.*—Careful physical examination in not a few instances prevented operating in cases having other diseases constituting contraindication to all but emergency operations, e. g., pulmonary tuberculosis, cancer of the stomach, nephritis, etc. Blood counts are of value, not only on account of determining the blood status at the time, but especially as a control when complications arise after operation. Some of the extended and complicated preparations have seemed to place the patient at the disadvantage of over preparation. Too much attention to the bowels is likely to be followed by a compensatory constipation.

*Operation.* With the exception of septic cases, intermuscular opening of the abdominal wall is always made. This in-

cludes operations on the kidney and gall bladder as well. In median incision the fibres of the rectus are separated. The abdominal wall in large tumors may be so thinned as to be not much more than double the thickness of the skin. In some cases the muscles are pale and brittle. The fascia varies in thickness and in texture, and the physical state does not seem to afford a basis for estimating this before operation. Not only is there marked variation in the thickness and resistance but also in the histological arrangement whereby there are spaces left at intervals by the longitudinal disposition of the fasciculi.

Blood vessels in the abdominal wall vary much and the increased number in septic inflammatory processes, especially the increase of the smaller branches, is very marked, while in malignant diseases the larger branches, especially the veins, are enlarged. This is also true of the chronic inflammatory processes, such as chronic appendicitis, tubercular peritonitis, and perosalpiux. In marking the incision in cases of very large solid tumors with greatly thinned abdominal walls with wide separation of the recti muscles, and especially when intestinal coils lie under the line of incision, care must be exercised.

After finding that anatomic coaptation could not be obtained by means of the through and through stitch; that buried silk worm gut is apt to cause long and serious trouble; after having late suppuration by using kangaroo tendon; finding catgut either too hard or too soft, I have finally used silver wire as a longitudinal stitch according to the method of Harris. The peritoneum and muscle are always coapted by means of the longitudinal catgut, the fascia by silver wire allowed to remain about two weeks; the skin is closed by means of a subcutaneous silkworm gut suture which is removed in about ten days. This method of closing has proved most satisfactory. The incision is usually as small as will permit the necessary technique.

On opening the abdominal cavity the field of operation is developed with as little manipulation of the peritoneum as possible and packed off from the remainder of the cavity by gauze. Whenever possible the omentum is brought down over the viscera. Manipulation of the viscera produces shock readily, manipulation of the omentum but little. In a long time, perhaps in the last hundred operations, no pedicle for any operation was formed, instead the dissection is carried out as in operations on the neck or extremities, vessels are isolated and tied, the parts

cut away and the wound closed by means of catgut stitches. In the removal of the largest tumors no pedicle is made. But few ligatures are used; instead, a catgut suture is made to include all the bleeding points, serving the double purpose of hemostasis and covering over raw surfaces. In suturing instead of ligation, there is no possibility of giving away. No raw spaces are allowed to remain, but are closed over by catgut suturing or omental grafts. Excepting in acute appendicitis with pus no drainage is used. In pelvic and tubal abscesses no drainage is employed. Flushing when used at all is done by pouring sterile salt solution from pitcher. For the most part moist sponges are used for cleansing the peritoneal cavity. After every particle of blood that can be removed has been disposed of and all the raw spaces closed over the omentum is brought down as an additional protection. In several instances the intestinal walls were damaged, even tore through in separating old adhesions, but immediate suture has thus far been successful; even in these cases no drainage is used. Oozing is controlled almost wholly by using the needle and catgut. With long retractors, a long slender needle holder and long dissecting forceps any portion of the abdominal or pelvic cavity may be sutured. In appendectomy the proximal end is turned in. In operation for gall stones the mucous membrane is removed and the peritoneal coat turned in, etc. No pedicles are made. The obliteration of the gall bladder, by removal of the mucous membrane, according to the method of Mayo yields splendid results.

Experimental research is corroborated by clinical experience in attributing different organs and tissues varying shock producing capabilities. Very rarely have stimulants been given during an operation—for during this time it is very difficult to estimate the part played by the immediate effects of the operative interference; if the patient has been placed under the influence of stimulants prior to the operation, it is more difficult to estimate the real resistance of the patient on account of the artificial condition instituted by the stimulant, hence no preoperation stimulation has been used.

Strychnia was used in relatively small doses repeated with sufficient frequency to secure physiologic effect in shock. In addition to this drug alcohol was used in all cases in which there had been absorption of toxins. Posture and heat are always employed, the former with marked benefit. Normal salt solution was



given intravenously in cases in which there was immediate and great danger. It is now well known that this solution will not remain in the vascular system. Given intravenously its effect is immediate but not likely to be prolonged, but given underneath the skin or per rectum a more sustained effect by continuous absorption is obtained. There are many points with regard to the use of the normal salt solution for which data are being collected for a future paper. From clinical experience the writer is convinced that in many cases over-stimulation is practiced. It is a matter of judgment as to how far to push stimulation and what stimulants are indicated. The most dangerous cases are those in which sepsis and shock are combined. In such cases the vaso-motor system has but little potential energy and break down comes early. The bowels are opened at the end of the first or second twenty-four hours by giving 1-10 grain of calomel every fifteen minutes until one grain is taken, after which milk of magnesia or one teaspoonful of epsom salts in hot saturated solution every half hour until four doses are given. If after this no movement follows, an enema of glycerine and epsom salts and water is given. This method nearly always succeeds. As to the after treatment of the wound, there is very little. In the majority of cases there is one dressing made at which the stitches are removed. The subsequent history of the case will be wholly determined by what happened during the operation. In every case in which I was able to make a short operation, clean cut wounds, little hemorrhage, close over all raw surfaces, the progress was most satisfactory.

*Results.* The most satisfactory clinical results of abdominal section followed the operations performed for acute appendicitis, for pyosalpinx, for gall stones and stones in the kidneys. The least satisfactory followed operations performed for subjective symptoms in the female, and among those cases I have had a number of clinical failures. The clinical results were far from satisfactory and in some cases the patient complained of more symptoms after the operation than before. The class of patients complaining of such symptoms as backache, pain in the sides, pain in the abdomen, headache, general nervousness, more or less insomnia with melancholia or even delusion, the class of patients whose pelvic organs under physical examination do not reveal any well marked disease have in my experience been clinically very unfavorable. Occasionally the removal of both ovaries has been

followed by good results. I have had clinical failures in making ventro-fixation of the uterus. It may be urged by some that good judgment was not used in selecting the cases and that in the hands of other operators better clinical results are obtained. My reply would be that I have had many clinical failures of other operators in my own charge in the hospital and have been given no end of worry in trying to devise some means of finding a relief. The operators themselves are frequently not aware of their clinical failures. I have had my own patients return with a mournful clinical story in no wise different from the patients that I have had to deal with who were operated upon by other surgeons. I have no doubt that there are patients of my own who have found the way to other hospitals seeking relief for the symptoms which I failed to cure. It has been some time since I have performed an operation upon the female genital organs unless I was able to make out on physical examination sufficient objective symptoms. There are extreme cases in which operation for subjective symptoms are indicated, and I have had some brilliant clinical results. From my own experience and the experience of others I would say that it is quite impossible to make a definite prognosis in operations for subjective symptoms. I have had several clinical failures, in cases of ventrofixation of the uterus. In several of these I cut down later and removed the adhesions. But after this pain would be complained of in other parts of the pelvis. I have tried these patients on ovarian extracts, and have sent them away, have changed their environments, exhausted therapeutic remedies, and many I have never succeeded in curing. Such cases as pyosalpinx, ovarian tumors, prolapsed ovaries, fibroids, etc., yield definite results and the prognosis may be clearly and confidently given. As to mortality rate, I have found it steadily decreasing as personal experience widens. At one time I performed 93 abdominal sections in two hospitals for every kind of disease and injury without a death. Following this satisfactory series I had two deaths. The question as to the mortality statistics is a very interesting one, and in my own cases the various groups have very different tables; for example, in a total number of 144 operations for appendicitis the number of deaths was eight. All these were in acute cases in which perforation had occurred without walling off—and the mortality rate in this class was 50 per cent. I have as yet not lost a case in which the abscess had been walled off com-

pletely and in which the acute symptoms had subsided, leaving the so-called "lump" in the side. In these cases the pathological examination of the pus sometimes proves to be entirely sterile, and if there are pathogenic organisms their virulence is very much reduced. As I said, I have never lost a case of this class, neither have I had any mortality in operations between attacks, nor in attack before infection had become extra-appendicular. In this group comprising 128 cases operated in hospitals, there has not been a death.

In the removal of large fibroids and large ovarian tumors I have occasionally lost a patient. In a series of 18 laparotomies for ventral fixation, 55 for operation upon the ovaries alone, 27 for operation upon the tubes alone, 24 for resection of the ovaries alone, a number of which were performed for subjective symptoms, 57 for operation upon both ovaries and tubes, making a total of 181, not a death occurred. Adding to this the 128 appendectomies above detailed, makes a total of 309 abdominal sections in which there was no death. Contrast that with the 50 per cent. mortality rate in cases of acute appendicitis, in which perforation without walling off had occurred, or contrast it with the cases of very large ovarian tumors in which there are extensive adhesions and in which the vitality of the tumor itself is markedly reduced, and especially the cases in which there is considerable fluid in the cavity, and it will be seen at once that the question of statistics is to a large degree the question as to the nature of the cases. Or contrast this mortality rate in these cases with operations performed for intestinal obstruction in which more than half my patients have died.

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## CROUPOUS PNEUMONIA IN CHILDREN.\*

J. PARK WEST, M. D., BELLAIRE, O.

In contributing this paper to the discussion today it was the understanding it was to go into details and to cover the subject as it relates to children under five years of age; consequently much of what will be said will be found better said in some of the text-books, but a review of the subject may be profitable. Broncho-pneumonia has for so long been recognized as peculiarly the pneumonia of children that many still believe that croupous

\*Read before the Eastern Ohio Medical Society.



pneumonia is rare in them, and do not realize that about one-third of the cases of pneumonia in children are of this latter variety. The disease differs but little from that seen in the adult, but owing to peculiarities in the thorax and lungs in children it is more difficult to recognize by physical signs.

*Symptoms.*—As a rule croupous pneumonia is a primary disease, but it often occurs as a complication, and oftener than the text-books lead us to believe it is preceded or accompanied by bronchitis. The beginning of a case is usually sudden, often by vomiting, not quite so often by convulsions, and still less frequently by a chill. Occasionally the child may have complained of an indefinite illness for a short time and then suddenly becomes quite ill. Whichever way the disease begins there will be found at once a high temperature, marked prostration, muscular weakness and every appearance of a severe illness from the beginning. All the symptoms that go with a high temperature, as the hot and flushed skin, dusky face, coated tongue, loss of appetite, malaise, quickened pulse and respiration, will be present. At this time there may, or may not, be symptoms that point to the lungs as the seat of the trouble. A physical examination will more than likely still leave us in doubt, for frequently the signs cannot be made out until the second or third day, and rarely not until quite late in the disease. Pain is only complained of in the minority of cases and is oftener said to be in the abdomen than in the thorax. The “short dry hack of pneumonia” best describes the cough; it may be late in appearing, it may be absent altogether, and is seldom a prominent symptom. So rarely is there expectoration that no further mention need be made of it. With any high temperature there will be found an increase in the frequency of the pulse and respiration, but in this disease the normal ratio will be disturbed by a greater increase in the frequency of the respiration than there is in the pulse. In health, as is well known, there are about ten respirations to thirty-five pulse beats, while in pneumonia and some other diseases of the lungs the ratio is changed to 10 to 25 or 10 to 20, or even lower. This perverted pulse-respiration ratio will often give us an early and may be the first clue to the disease, and is, to my mind, one of the important signs; it points to the seat of the disease and occurs early when distinctive signs are particularly needed. After twenty-four hours the disease is usually well-defined as far as symptoms are concerned. The child is quiet and wants to be let alone. The face is flushed and

drawn, the nares active, the skin dry and hot. The temperature is high and continues so. The bright flush on one or both cheeks may be seen occasionally for a short period. Everything points to a severe sickness and the quickened breathing attracts attention. This is usually accompanied by a moan or grunt, the pause occurring after inspiration instead of after expiration as in health. The breathing is also rather distinctive in that there is seldom any real dyspnoea, but only an increase in the rapidity. Owing to the rapid breathing crying is indulged in to but a slight extent and nursing by a few hurried draws and a longer rest. The cough, which may be but seldom, is annoying, is often suppressed, oftener, it has seemed to me, on account of the jar to the head and body than from pleuritic pain. Appetite is usually entirely absent. This condition continues for from five to eight days, rarely longer, when there will be noticed a slight improvement in the general condition, and in a few hours a marked drop in the temperature, down to or even below normal, and a great improvement in all the symptoms. This crisis occurs in about two-thirds of the cases. In the other third, and this applies more particularly to children under two and a half years, the temperature falls more slowly with a general improvement and a gradual let-up in the severity of the symptoms. The termination may be prolonged for several days with or without the involvement of other areas of lung. After there is an eruption of labial herpes.

The physical examination of the lungs gives the most valuable evidence of the disease, and a few words in regard to the subject in general before speaking in reference to this particular disease may not be out of place. Many who examine an adult's lungs with minute care will make a very cursory one of a child's and conclude not much is to be learned by the procedure. A little care and much patience will give results just as valuable as can be obtained with the adult. One must not try to follow any set routine but be ready to vary his course to suit the whims of his patient. It is not always possible to make a complete examination at one time or even at one visit; whenever this is so re-examinations should be made at every opportunity until a satisfactory result is obtained. Because the child cries and squirms the examination should not be given up; just as good results can be obtained by palpation and auscultation as when the child is quiet. Frequently more can be learned from the voice and the long-drawn inspiration during crying than from the superficial

respiration when quiet. Often it is only in this way the crepitant rale can be heard. Auscultation will give more satisfactory results than any other of the methods to be used and should be practiced first before the child becomes tired and restless. For this a binaural stethoscope is necessary to make a complete examination. From previous discussions here I know this latter statement will not be accepted by all. The axillary spaces cannot be examined with the ear alone, nor can the apices without putting your head to the child's face, which will very seriously disturb the child, nor can we detect (except probably accidentally) very small areas without the stethoscope, and while more is obtained from an examination of the back it is just as necessary to examine the sides and front. Physical examination in children and the interpretation of the signs obtained are not always easy nor are they as difficult as many think. The one great drawback is the lack of care, of persistence, and of making repeated examinations. Three things should always be remembered when examining a child for croupous pneumonia. First. The left lower lobe is most frequently affected, next the right apex, next the right base, and next the left apex. Second. The disease may only be found in the apex or in the axilla and may not involve a whole lobe. Third. The liver dullness extends to the fifth rib in front, to the seventh on the side, and to the ninth in the back, and that crying may cause it to extend considerably higher, particularly in the back. Not infrequently physical signs are late in appearing and may not be found until after the crisis, and there have been undoubted cases of the disease where no physical signs were made out at all. The rude, harsh breathing of the child, so different from the normal vesicular murmur of the adult, is usually greatly intensified in croupous pneumonia, so much so as to make one think he hears bronchial breathing over both lungs. This intensified breathing is only heard on inspiration, the expiratory sound being very weak and at times almost absent. Before complete consolidation there may be heard only weakened respiration over the pneumonic area. When consolidation is completed bronchial breathing is heard, the sound on inspiration and expiration being very much alike. The crepitant rale that we learned as pathognomonic of croupous pneumonia is oftener absent than present, so not much reliance is to be placed on it. If heard at all it will be at the end of a deep inspiration and must not be confounded with the friction sounds that are heard on both inspiration and ex-



piration. After the beginning of resolution other rales will be heard. With consolidation there will also be bronchial voice. If the child is not old enough or cannot be made to speak he can be made cry when the voice or cry will be louder, high-pitched and appear as if coming from directly under the stethoscope. Bronchial voice and bronchial breathing are usually found together, but often there is the former and not the latter and bronchial voice may be the first sound elicited.

Palpation gives increased vocal fremitus over consolidation. In palpating better results will be obtained by using the edge of the hand instead of the palm; it is more sensitive, covers a smaller space, and is better adapted to the chest walls.

Percussion should come last, for children object more to this than to the other methods. Great care is necessary on account of the thin chest walls and the delicate lungs. The stroke should be very light or a tympanitic note will be obtained over a small consolidation, or there will be vibrations from organs at a distance. The same location over the two lungs must be closely compared and percussion must not be made on one side during inspiration and on the other during expiration, as this will give a difference in the sounds. Early in the disease there is some impairment in the resonance that is later increased to slight dullness, but seldom to the same extent as found in the adult. The sense of resistance to the percussed finger should be noticed; it may be slight, but it is perceptible and is quite an aid at times.

*Differential Diagnosis.* Leaving out of consideration other acute infections which, like pneumonia, may begin with vomiting, convulsions, or chills and a high temperature there are to be considered the gastric, cerebral, and migratory types of croupous pneumonia, bronchitis, pleurisy, and broncho-pneumonia. *Gastric pneumonia.* In occasional cases the symptoms on the part of the gastro-intestinal canal are so marked as to direct one's attention away from the lungs entirely. There will be vomiting, diarrhœa, anorexia, dry-coated tongue, and pain in the abdomen with a very high temperature. There may be no cough or a slight one such as might accompany any disease with the temperature present. If the disease be pneumonia these symptoms become lessened as the disease progresses and the symptoms on the part of the lungs will become more prominent. In gastro-enteric trouble the temperature will not be so high nor so continuously high, nor will the child be so prostrated. In these cases a careful observation of

the pulse-respiration ratio and the recollection that the abdominal pains may be reflected pains will direct attention to the lungs. *Cerebral pneumonia.* In some cases the cerebral symptoms are very prominent. It was formerly thought this was the case when the apex of the lung was affected, but this is now known not to be so. These cases resemble meningitis so closely that it is often not until after the crisis that one realizes he has been dealing with a case of pneumonia, and the condition may be still more puzzling if the physical signs are late in appearing and the amount of lung tissue involved is small and hard to find. It is also to be remembered that meningitis may occur with or complicate pneumonia. The disease may begin with convulsions, to be followed by delirium, stupor, retraction of the head, vomiting, irregular pupils and even other signs of meningitis. In meningitis the pulse is slow and irregular, as is also the respiration; in pneumonia both are fast, with the respiration hurried out of proportion to the pulse, while the active nares, the expiratory moan, and the herpes are not seen in meningitis. In pneumonia the temperature is continuously high and in meningitis lower and irregular. If the symptoms are due to meningitis they will begin suddenly during the course of the disease and continue, while if due to pneumonia they begin with it and shortly become milder and to a great extent disappear. *Wandering or migratory pneumonia* is that form due to successive involvement of different parts of the lungs and will be considered with broncho-pneumonia as it is to be differentiated largely by the physical signs.

*Bronchitis.* In this there is not the abrupt beginning, the prostration, nor the high temperature. Should there be a high temperature early it soon falls. Bronchitis is usually preceded by a coryza and the cough is hoarse and harsh instead of short and hacking. It is by no means so severe a disease except when it terminates in broncho-pneumonia, which, on account of the structure of the lungs in children under five years, it has a tendency to do. The physical signs are markedly different and are not confined to one side, to a lobe, or to a part of a lobe. Early in bronchitis auscultation will reveal sibilant and sonorous rales over both lungs; later these are replaced by mucous rales. The finer mucous or sub-crepitant rales will not be misleading if we remember it is a moist rale and is heard on inspiration and expiration, while the crepitant rale is dry and is only heard on inspiration and as a rule only at the end of a deep inspiration.

Fremitus will not be increased nor will there be dulness or bronchial breathing.

*Pleurisy.* In acute pleurisy the symptoms are usually milder, the prostration not so great, and there are more evidences of pain early. It is hardly necessary to go into details concerning pleurisy farther than to say that it often follows pneumonia, or one side of a chest may be found filled with fluid with few or no previous symptoms, and that it may be mistaken for an unresolved pneumonia. In differentiation the main reliance is to be placed on the physical signs, but if a physical examination still leaves one in doubt all that has been obtained by auscultation should be left out of consideration. All kinds of rales may be heard or again there may not be a rale of any description heard over the affected side. The respiratory sounds may be the same on both sides when one side is full of fluid. There may be the crepitant rale and bronchial breathing just as is heard in undoubted cases of croupous pneumonia. Therefore the signs heard on auscultation are so misleading that no attention should be paid to them. Percussion gives flatness that is distinct from the dullness over a pneumonic area. In percussing as much can be learned from the sensation of resistance to the percussed finger, as by the sound the sensation is that felt when percussing over a solid organ. Im-mobility of the affected side is to be seen, and oftener bulging of the whole side than of the intercostal spaces. Much stress has been put on displacement of the heart in pleurisy with effusion. In children this almost never occurs in right-sided pleurisy, and seldom in left-sided and then only with a very large effusion. The normal voice fremitus will not be felt when there is considerable effusion. This is a valuable sign and should be elicited by making the child speak or cry. The crucial test is the hypodermic syringe.

*Broncho-pneumonia.* This is generally a secondary disease preceded by a bronchitis, with or without a coryza, while croupous pneumonia is primary and begins, suddenly with well-marked symptoms. In the former the skin is not so hot and pungent, but in the midst of a severe case may be cool and moist. The prostration and general weakness are not so marked until later in the disease; this applies particularly to those cases following a primary bronchitis and not the infectious diseases. The general course of the disease is more varied and irregular while croupous pneumonia runs along very much the same from day to day. The



temperature raises gradually, is not so high nor so regular, and the daily variations are greater. There is no critical fall. The cough is more constant and in paroxysms. Dyspnoea is a marked symptom in broncho-pneumonia and to the rapid breathing of croupous pneumonia is added the labored breathing with more or less cyanosis and sinking in of the soft parts of the chest. There are also paroxysms of dyspnoea. The most marked differences on physical examination are that in broncho-pneumonia the signs are found in both lungs, occupy principally the posterior part of the lungs, are never confined to one apex or axilla, and the consolidation is not so complete nor covers such a large area. Over both lungs will be heard the same rales as in bronchitis, first sibilant and sonorous and later sub-crepitant. Over the congested area will be heard very fine sub-crepitant rales in addition to the above. At this time there will be no change in the resonance on percussion, but as consolidation begins (later than in the croupous form) there will be slight dullness with a less well defined area. Over this will still be heard very small rales with indistinct bronchial breathing. With complete consolidation there are bronchial breathing, bronchophony, and voice fremitus, with dullness more distinct. These signs may be marked in one lung and only partially so in the other. They may be confined to a very small area or areas or cover a very large space. Croupous pneumonia never gives these varying signs and they are always heard in the same place unless there is an extension of the disease.

*Treatment.* The mortality is very low, being only 4 to 6 per cent., and we should beware of trying to do too much. Some of the members of the society are firm in the belief that they can jugulate pneumonia, but I would remind them that it is a self-limited disease, that some cases run a course of but two or three days, and that there are abortive cases of even shorter duration. If poultices may have a place in bronchitis and broncho-pneumonia, they certainly do not in this disease; an exception may be made for the occasional application of a mustard poultice for the relief of pain. There is no routine treatment and often no drugs are called for; expectorants are not needed unless there is a troublesome bronchitis. An abundance of fresh air should be provided and no food forced on the patient unless there is progressive weakness. A small quantity of whisky and weakened milk are the preferable foods. The child should be watched closely and at the first sign of failure stimulation should be begun with

brucine or strychnia, digitaline, or whisky. With the extreme depression that sometimes follows the crisis nitro-glycerine, frequently repeated, in addition to the above, is very valuable. If there is much pain or excessive cough small doses of codeine may be given and stopped as soon as the result desired is obtained. An occasional dose of phenacetine will sometimes quiet restlessness and often reduce the temperature when going too high; much care is required in the use of this drug and it should not be repeated often. High temperature is an indication of danger, but is not to be treated as a thing of itself, but should be considered an index of the infection and be treated as such. The effect of the temperature, or rather the infection, on the nervous system furnishes the indication for treatment. One child with a temperature of 103 degrees may have more nervous symptoms than another with 105 degrees, and if there is either great restlessness or drowsiness, increasing prostration, convulsions or any tendency thereto measures should be taken at once to relieve them. Nothing meets the indications in these cases as well as the bath. A bath at 95 to 100 degrees F., with constant gentle rubbing of from three to ten minutes' duration is very soothing and strengthening. It is to be repeated as needed and no routine is necessary with this measure. Rarely one or two cooler or cold baths will be required.

3608 Belmont street.

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## EARLY INTUBATION IN LARYNGEAL DIPHTHERIA.

BY WILLIAM E. LOWER, M. D., CLEVELAND, O.

In a paper before the State Pediatric Society, in May, 1898, I called attention to the mortality due to certain accidents in the act of intubating and extubating the larynx. It was also advocated at that time the importance of early intubation in beginning obstruction of the larynx. My experience of the past 18 months has convinced me that sufficient emphasis was not attached to the importance of early intubations in beginning laryngeal obstruction in diphtheritic cases. Recent statistics show that in diphtheritic cases treated at the very beginning of the disease by the serum treatment, the mortality rate does not exceed 1 per cent., but the mortality rate increased proportionately to the length of time between the onset of the disease and the introduction of the serum treatment, so that the mortality for all cases treated at all

stages of the disease is between 5 and 6 per cent. In no small per cent. of the fatal case, the death is due to suffocation from laryngeal obstruction, when intubation is not practised, or to broncho-pneumonia following late intubation. This can be easily understood when we are reminded that in most cases upon which we are called to intubate, the child is completely exhausted from being insufficiently supplied with oxygen and from continuous laborious breathing. Mucous and septic material may readily get into the tube and trachea, and quickly produce fatal inflammation. There is no resistance, and scarcely any attempt or effort to dislodge the foreign substance. A broncho-pneumonia ensues and the already exhausted septic child quickly succumbs. This is not the case when intubation is practiced at the very beginning of laryngeal obstruction. Within the last year and a half I have had occasion to do intubation for physicians who believe in very early intubation in laryngeal obstruction, and we have not lost a case in which intubation was practiced early, while in the late cases the mortality is about 50 per cent.

The advantages in favor of early intubation are: First, the child is stronger, has greater resistance and can bear the operation better. Second, the time for the wearing of the tube is lessened, generally not requiring over 24 to 36 hours. Third, by shortening the time of wearing the tube the amount of nourishment required is less; there is less opportunity for the introduction of septic material into the trachea, and consequently less chance of septic or broncho-pneumonia, which is nearly always the cause of death.

Of course, in all cases of diphtheria serum treatment should be practiced and the earlier it is used the greater will be the percentage of recoveries. It is to be regretted that in this day and age, after the most thorough and convincing proofs of the value of antitoxine in the treatment of diphtheria, there still remains a certain number of physicians (not many, but there should be none) who refuse to use or at least do not sufficiently urge the serum treatment. There should be no excuse for not using this remedy. If the patients are too poor to purchase the antitoxine the city should, and I believe does provide it.

The indication then for intubation is the very beginning of laryngeal obstruction, when the breathing first becomes labored and not to wait for the cyanotic stage, as is now generally done. The first symptoms will be prolonged inspiration, slight stridor,



supra clavicular retraction and marked restlessness. Antitoxine, if it has not already been given, should be used at once, in large doses. Nothing should be given by the mouth. Rectal feeding resorted to, if any nourishment be necessary, moist atmosphere in the room is better than dry. By this method we feel positive the mortality rate in laryngeal diphtheria can be greatly lessened.

*The Osborn.*

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## THE CLEVELAND MEDICAL LIBRARY ASSOCIATION.

### THE PRESIDENT'S REPORT, 1899.

#### *To the Trustees of the Cleveland Medical Library Association:*

Gentlemen:—The library-year just closing is of special interest, in view of the facts that the first burst of enthusiasm which greeted our removal to our new home has now had an opportunity to sober itself, and that the past year has been the first year of our strictly independent existence and has, accordingly, supplied the first trustworthy data upon which to base our action in the future.

On the whole, I think the record will show, in spite of some discouragements, much that is hopeful and promising.

The Council at its first meeting was confronted with the resignation of the newly elected Secretary, Dr. J. C. Wood, whose numerous other duties forbade his accepting the somewhat onerous labors of the office to which he had been elected by the Association. In this emergency Dr. F. S. Clark was elected by the Council to the vacancy, and he has continued to perform the duties of Secretary with the utmost efficiency and acceptability.

Our roll-call contains the names of 120 members of all classes, a net increase of 8 since our last report. Only 3 resignations have occurred during the year.

The register of visitors for the year contains 766 names, to which number may be added, I am sure, not less than ten per cent. for those visitors who have failed to register their attendance. There seems, indeed, to prevail a general misapprehension as to the purpose of the register maintained in the hall of the Library. Many physicians seem to regard it as intended for casual visitors only, and for those not members of the Association. This, however, is not the fact. The Register is designed to preserve a record of *all* visitors, whether members of the Association or not, and

thus to secure for the officers an index of whether, and how far the arrangements of the Library are meeting the needs and wishes of the medical profession.

In my last Annual Report the number of bound volumes upon our shelves was stated to be something over 4,000. The additions during the year have been 1,023, and the total number of volumes in the Library at present (including 550 duplicates) is 6,072.

The more important donations of the year have been made by the following persons: The Hon. Judge Dellenbaugh, Drs. Dudley P. Allen, W. F. McLean, C. A. Hamann, N. S. Scott, H. G. Sherman, G. S. Iddings, A. G. Hart, B. L. Millikin, Sister Charles, Charity Hospital and Mrs. P. A. Gordon, to each of whom the Council has by resolution expressed its hearty thanks.

In this connection mention should be made of a valuable addition to our Loan Collection, made by Judge H. C. White, consisting of a complete set of 54 volumes of the *Journal of Insanity*. It is hoped that other loans may be added to our present collection and that the latter may eventually become an attractive and useful department of the Library.

The number of foreign and domestic journals procured by subscription during the past year has been 46, and we have again to offer to the *Cleveland Medical Journal* our sincere thanks for copies of their exchanges contributed regularly to our journalistic files. The whole number of journals represented upon these files is 147.

Early in the year a Bureau of Nurses was organized in connection with the Library, and has been in operation with moderate success ever since. What it needs to render its success complete is the hearty co-operation of the members of the Association. If they will always bear it in mind, and give it their preference when they have occasion to employ nurses, there is not the slightest doubt that the Bureau will be a genuine boon to the profession and to the nurses themselves, as well as a credit to the Association. No care or pains are spared in securing the history and qualifications of all nurses whose names are found upon our roll, and I feel convinced the Bureau may be trusted with entire confidence.

The stenographic and type-written work of our very competent Assistant-Librarian is well known by experience to many members of the Association, and is commended to all persons requiring such literary aid.

An effort to extend the usefulness of the Library has been made by a resolution of the Council, which authorizes matriculated students of any of our medical colleges to enjoy reading privileges in the Library, on the payment of an annual fee of \$2.00 and presenting an application for such privileges, endorsed by the Dean of their Faculty and a member of the Board of Trustees of the Association. The Faculty of the Medical Department of the Western Reserve University has already secured such privileges for the entire senior class of that college, and it is not improbable that similar action will be taken by other colleges of the city.\* The advantages of cultivating in our medical students the habit of reading, and of teaching them what to read and how to read, are too apparent to require more than simple mention.

Until recently a severe and just criticism upon the Library has been its deficiency in the most modern text-books and works of reference, which constitute the daily apparatus of the practicing physician. To this deficiency the Council has been neither insensible nor indifferent. But the stern necessity of confining their expenditures within the somewhat uncertain and untried limits of their annual income forbade the appropriation of the funds entrusted to their care to any but the most indubitable and indispensable requirements of the Library, and warranted no prodigality based upon presumptions of future revenue. An effort was made to remedy the deficiency by the personal solicitation of subscriptions for the purchase of new books, but it met with little success. In this emergency one of the Council, a tried and proved friend to the Library, came forward with a personal and generous donation of \$200.00, which our indefatigable Librarian soon converted into the fine collection of modern text-books that now adorns our department of "New Books." Further subscriptions either for the general purchase of valuable works, or for that of specific books indicated by the subscriber, will be gratefully received and economically expended by the Librarian.†

The comparatively bare walls of our various rooms plead loudly for the decoration of pictures, medical curios and bric-a-brac, and an appeal for such embellishments is made to the profession generally. No more appropriate place for the preservation of medical antiquaria, portraits and other pictures can be

\* A similar privilege has been extended by the faculty of the Cleveland College of Physicians and Surgeons to the senior class of that institution.

† Subscriptions for this purpose, amounting to \$170.00, were made at the meeting of the trustees, and a special committee, consisting of Drs. B. L. Millikin, D. P. Allen and G. A. Stevens was appointed to continue the work among the profession and others interested. Something like \$500.00 has been already secured by this committee.



found than that offered by the walls, mantels and cases of the Library, where they will not only be preserved with care, but will also serve as object lessons for the coming generations of medical men.

The income and expenditures of the Library for the current year as deduced from the reports of the Chairman of the Finance Committee and the Treasurer, have been as follows:

Income from all sources.....	\$3,934 38
Total expenditures .....	1,775 47
<hr/>	
Balance .....	\$2,158 91
The Permanent Fund invested at 6 per cent. is.....	\$5,779 50
On hand awaiting investment .....	1,909 60
<hr/>	
Total .....	\$7,689 10

In conclusion I desire to express my hearty thanks to the officers of the Association for their cordial support and advice in the often perplexing duties of administration, and to thank you all, gentlemen Trustees, for your attendance and interest this evening.

Respectfully submitted,

H. E. HANDERSON, President.

### **For the Removal of Foreign Bodies from the Nose and Ear.**

Sturrock (*British Medical Journal*, November 25, 1899, p. 1473) recommends the following mode of procedure: The presence and approximate situation of the foreign body having been ascertained, a piece of india-rubber tubing, rather less in diameter than an ordinary lead pencil, varying in length from one to three inches, and attached to the nozzle of a brass syringe, is introduced into the nostril or meatus, as the case may be, and brought into contact with the foreign body. The piston of the syringe is then pulled out for a sufficient distance to create a vacuum in the tubing, and thus draw the foreign body into or against its free end. The syringe is then withdrawn and with it the foreign body attached to the tubing. In some cases it has been found advantageous to dip the tubing into glycerin before insertion, in order to diminish the chances of air entering between the tubing and the foreign body.

# THE Cleveland Medical Gazette

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## Editorial.

### WHO IS RESPONSIBLE FOR THE SPONGES IN A SURGICAL OPERATION.

This question is to be settled in the courts in the case of Taylor against Dr. J. F. Baldwin, of Columbus, the latter having been sued for damages, since the death of Mrs. Taylor. The question has been pretty definitely settled already in the minds of the medical profession, and of the nursing profession as well. The particulars of the case may be gathered from the following affidavits. The first is that of Dr. B. A. Thomas, Mr. Taylor's family physician, of Rushville, who was present at the first operation:

State of Ohio, Fairfield County, S. S.:

Dr. B. A. Thomas, being first duly sworn according to law, says that he was present on the 26th day of May, 1899, and assisted Dr. J. F. Baldwin operate upon Mrs. William Taylor, of this county, at the Protestant Hospital, Columbus, Ohio. That said J. F. Baldwin made an incision of about five inches in length in the lower abdomen over the uterus; that at the close of the operation in this incision said Baldwin asked the attending nurse of the Protestant Hospital if she had her proper number of sponges, that the said nurse, Miss Allen, replied that she had; that thereupon said incision was closed.

Affiant says that a second incision was made immediately over the gall bladder about three and one-half inches in length, and from said incision a gall stone was removed; that after said operation was concluded said Dr. J. F. Baldwin asked said nurse, Miss Allen, if she had all her sponges; she replied in the affirmative, and just before the incision was closed, out of an abundance of caution said Baldwin again asked said nurse if she had all her sponges, and again she replied in the affirmative. Affiant says that the second incision was then closed; that after said Baldwin asked the said nurse if she had her proper number of sponges, that he, Baldwin, did not ask for, neither did he use, another sponge in closing that, the second, incision. That the second incision was of such a nature that another sponge was unnecessary in closing said incision. That no sponges were used in either case after the nurse was asked if she had her sponges.

B. A. THOMAS.

Sworn to before me and subscribed in my presence this 2d day of October, A. D. 1899.

A. B. MORTAT.

Notary Public in and for Fairfield County, Ohio.

The following is the affidavit of Mr. Sylvester J. Goodman, who was the hospital interne and present at both operations:

On this 3d day of October, A. D. 1899, before me a notary public for the Commonwealth of Pennsylvania, residing in the city of Philadelphia, personally appeared Sylvester J. Goodman, who being duly sworn according to law, doth depose and say: \* \* \* "On or about the 27th day of May of this year I anesthetized Mrs. Taylor for an operation on the gall bladder, performed by Dr. J. F. Baldwin, assisted by Dr. Chapman. Miss Lillian Allen, the chief nurse, had charge of the sponges. Mr. Taylor and Dr. Thomas, the family physician, were present. Before closing the incision I distinctly heard Dr. Baldwin ask Miss



Allen if all the sponges were accounted for. She counted them and announced there were eight small and four large sponges. Dr. Baldwin then closed the incision without putting any sponge in it either deep down, or just under the superficial layers, or at all. I cannot remember of any time when operating gall bladder, or appendicitis cases that he put a sponge under the line of incision. I was present when Mrs. Taylor returned to the hospital on the evening of August the first, and assisted her to bed. The next morning I went into the operating room, just after Doctor Baldwin had commenced to operate. I washed up and prepared to assist. Miss Allen was again in charge of the sponges. Dr. Baldwin showed where the abscess had perforated the duodenum, and on examination of the parts thereabout discovered a greenish looking wad. This proved to be a sponge. He said nothing at that moment, but a few minutes later asked Miss Allen if she had all her sponges. I remember distinctly she said yes. He said, 'Did you count them?' She answered that she did. He replied there are nine sponges here. We counted them over to be certain of the count. Miss Allen said that perhaps there had been nine instead of eight small sponges put into the package in the sterilizing room. Dr. Baldwin asked her if she always counted them before the commencement of an operation. She said they were supposed to be counted in the sterilizing room. She could not account for the extra sponge. I cannot remember any operation of Dr. Baldwin's in which he failed to ask for a count of the sponges after the operation. He was most exacting on this point.

SYLVESTER J. GOODMAN.

Sworn and subscribed to before me this 3d day of October,  
A. D. 1899. Wm. J. DIVINE, Notary Public.

State of Ohio, Franklin County, S. S.:

The deposition of Dr. Baldwin's assistant, Dr. L. J. Chapman, is as follows:

On or about the 27th of May, 1899, I assisted Dr. J. F. Baldwin in an operation upon Mrs. Taylor, of Fairfield county. The operation was made at the Protestant Hospital, Columbus, O., and Miss Allen, the chief nurse, had charge of the sponges. Two incisions were made, one in the median line just above the pubes, and later one over the gall-bladder. Just before each of these incisions was closed, Dr. Baldwin asked Miss Allen if she had all her sponges. She counted and said she had them all. - There was no sponge inserted after either of these counts. Both of these in-

cisions were closed in layers and no sponge was needed under the abdominal wall while closing, as with through and through sutures.

I have assisted Dr. Baldwin in practically all his operations for three years and I have never seen him place a sponge under the abdominal wall while closing incisions over the appendix or gall bladder, because these incisions are always too short for this procedure.

I also assisted in the operation upon Mrs. Taylor at the Protestant Hospital about August 1 and saw Dr. Baldwin remove a sponge squeezed into a wad and saturated with bile, from under the liver and behind the gall bladder. Nothing was said of it then. Before closing Dr. Baldwin asked Miss Allen, who again had charge of the sponges, if she had them all. She replied affirmatively. He asked if she had counted them and was told she had eight. He still had one in his hand. A re-count, therefore, revealed nine. Miss Allen could not account for the extra sponge, but said the mistake might have occurred in the sterilizing room where the packages were put up. From the position and condition of the extra sponge it was evidently one of those used to hold the bowels away from the gall bladder incision in the first operation.

Miss Allen's suggestion that the mistake might have occurred in the sterilizing room, calls to mind the fact that six weeks subsequent to Mrs. Taylor's first operation, a package of sponges containing thirteen instead of twelve was procured directly from the sterilizing room at the Protestant Hospital for an operation in the country.

LEE. J. CHAPMAN, M. D.

Sworn to before me and subscribed in my presence this 11th day of November, 1899.

OSCAR E. HALTERMAN,

Notary Public in and for Franklin County, Ohio.

The efforts of the defense have elicited opinions from prominent surgeons in various parts of the country. Drs. Parker, Robb, Rosenwasser, Allen and Humiston, of Cleveland; Reamy, Conner and Ransohoff, of Cincinnati; Reeve, of Dayton, and numerous others have stated positively that accepting the statements of these affidavits as to what took place, Dr. Baldwin had used all the usual precautions to obviate accidents of the kind.

Every abdominal surgeon operating in a hospital with the assistance of trained nurses is accustomed to trusting a nurse charged with that duty to count the sponges before the operation and again when the surgeon is about to close his incision.

Numerous trained nurses and superintendents of training schools give the same opinion, namely: that the trained nurse takes upon herself certain duties which she has been trained to perform and which entitle her to higher compensation than an untrained nurse; and it is generally understood that one of these duties in certain cases is to account for the sponges. It seems to us that Dr. Baldwin has two good trenches between him and the enemy. First, it is thoroughly understood by both physicians and surgeons on the one hand and nurses on the other that the profession of the trained nurse is a separate and distinct profession from that of medicine and surgery. That in modern hospital practice the physician or surgeon can no more be expected to do the nurse's work than he can that of the pharmacist, or that of the anaesthetiser during an operation. If an operator uses due care in selecting his assistants, including nurses, from among those legally qualified to practice their respective professions they must each be responsible for the proper performance of the duties belonging to their own profession, and that in this instance the operator used the "ordinary care and skill" which the law requires when he called upon the nurse to see if she had all the sponges before he closed the cavity. Secondly, even if this position were to be denied and it be held that ordinarily nurses and assistants are employes of the surgeon and the surgeon should be responsible for the acts of his agents, Dr. Baldwin would still have a defense. For in this case the nurse was not chosen or employed by him. She was an employe of the hospital. The patient or her friends themselves engaged the room at the hospital, virtually engaging the nurse's services at the same time, for it was understood that the patient was entering the hospital for its care and nursing through her operation. If the responsibility for the nurse's services reaches any farther than the nurse herself it must rest upon the hospital employing her, and not upon the surgeon who went there to operate, using such aid and such assistants as the hospital furnished.

If there was any logic in the verdict finding powers of the average jury we could predict for the defendant in this case a certain victory. We shall watch for the result with interest, and if Dr. Baldwin wins, as we hope he will, it will be worthy of note upon what ground the defense is successful. Whether upon the ground that the nurse belongs to an entirely distinct profession for whose conduct in her peculiar line of duty the medical man is



never responsible; or upon the ground that this nurse was not employed by the doctor, but by the patient independently of the doctor. This point might have an important bearing in cases occurring in private hospitals where all the nurses and assistants are employed and paid by the physician or surgeon proprietor; or in cases in which the physician or surgeon employs the nurse or even selects the nurse to go to a private house. Such circumstances might be considered as quite altering the doctor's responsibility—as quite different from the case in which the nurse was an employe of a hospital over which the doctor had no control. If such a precedent be established physicians and surgeons would best govern themselves accordingly.

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#### SHALL WE CHARGE FOR MEDICAL ADVICE GIVEN BY TELEPHONE.

The telephone is not an unmixed blessing. Although we hardly see how we ever got along without it, we are sometimes tempted to declare we wish there were no such thing in existence. The interruptions it causes are innumerable and most exasperating. The night calls are undoubtedly increased by this convenience for summoning the doctor. Of course the telephone often obviates the necessity of a trip; sometimes when the doctor does not want it and again sometimes when he would rather make it. On the other hand, it enables people to annoy the doctor with unnecessary interviews. Necessary or unnecessary, they take the physician's time and his knowledge and tax his nerves, and he sometimes poses himself with the query whether he ought to charge for those interviews. With some patrons such a charge would be paid without a question. They never ask for an itemized bill, and the doctor, feeling that he is absolutely trusted, is extremely careful to be perfectly just or to lean to the side of generosity in his charges. Other patrons would not like to be charged for a few minutes' advice over the wire. Now, there ought to be a general understanding, and some kind of a rule to go by in dealing with this matter. The individual case must be left to the doctor's knowledge of his people and their circumstances and the doctor's own conscience. We believe the profession is pretty liberal in giving advice in many cases where it is hardly expedient to charge a fee. And again it is sometimes

justifiable to charge a fee where it would be hard to specify the service rendered. We are told that the account book of the famous Irish surgeon, Dr. Colles, showed many such entries as this:

"For giving ineffectual advice for deafness, 1 guinea."

"For telling him that he was no more ill than I was, 1 guinea."

"For nothing that I know of except that he probably thought he did not pay me enough last time, 1 guinea."

It was not the doctor's fault that the deafness was found to be incurable; nor that a person who was not ill sought his advice and required him to ascertain that no disease was present.

Evidently Dr. Colles thought that whoever took his time and attention, and professional knowledge should pay for them. He was right. And that is a good general rule to go by in this telephone problem.

Another good rule would be that when advice or a prescription by telephone obviates the necessity of a visit or an office consultation it should be charged for.

Otherwise the doctor's time and his gray matter are drawn upon without compensation, and he is further drained by having to pay for the very apparatus that is used to extract them from him.

KELLEY.

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### A CAUSE FOR REGRET.

We regret to learn that the medical students of our Cleveland colleges are endeavoring to defeat the proposed law for regulating medical practice in this state, and we are sorry to see that they have, in this matter, taken a step contrary to the best interests of the profession.

The medical charlatans, quacks and imposters, with whom our state is infested, for obvious reasons dread an examination, and we expect them to oppose progress and to stand for all that is degrading and pernicious, but why should the medical students of our city find the ordeal of examination so distasteful? The two regular schools in Cleveland have no mean reputation, and their students, or at least those of them who are honest, upright and ambitious and who, we presume, have the welfare of the profession at heart, should not be little those institutions by insinuations, that they, as representative students, are unable to meet the requirements proposed by the state.

We do not believe that the strong are afraid of the test, and the sooner the weeklings are weeded out the better, both for the profession, and for humanity itself.

It is due to our Cleveland students to say that the movement originated in a "Medical School" located elsewhere in the state—one of notoriously low reputation, and indeed little more than a diploma mill—we do not believe that the Cleveland men were aware of the true inwardness of affairs when they took the matter up.

We close by quoting an editorial from the *Journal of the American Medical Association*:

"STUDENTS AGAINST PROGRESS.

"The students of the medical colleges of Cleveland, Ohio, or a portion of them, have organized to defeat the proposed law regulating the practice of medicine, which is supported by the profession of that state. In so doing they go beyond the Iowa students who would have only themselves exempted from a state examination, for they unselfishly (?) demand that neither they nor anyone else shall be examined, unless all present practitioners in the state shall go through the same mill. As there are legal and constitutional objections to this last, their position amounts simply to a demand that no medical reform shall succeed, and they place themselves on the level of the quacks who are fighting medical practice acts throughout the country. Making all the allowances for the average unwisdom of immature undergraduates, this is not a very pleasant matter for contemplation, and the more general the movement the worse the case. One is tempted to hope that young men who have no better ideals as to their chosen profession than to join forces with its outlaws, will never get into it, at least not until they have had the full benefit of an extra rigid state examination. Ohio would better, for its own sake, pass such a law at once, with an emergency clause attached." G. S. S.

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## Periscope.

*Absorption of Iodin Oils.* By ROBERT ROESEL (*Pflueger's Archiv*, 1899, 22).—Experiments on human beings show that the iodine of iodised fats is more quickly absorbed than is the iodine from inorganic compounds. In 51-58 hours, from 43 to 79 per cent. of the iodine was recovered in the urine.



*Artificial Nutrition of a Normal and of an Atrophic Infant.* By MAX RUBNER and OTTO HEUBNER (*Zeit. Biol.*, 1899, 315).—A lengthy and detailed account of the metabolism and heat formation in two infants brought up by hand; one child was healthy, the other atrophic and feeble. The points of difference are numerous, as would be expected.

*Formation of Fat from Proteid in the Cat.* By MAX CREMER (*Zeit. Biol.*, 1899, 309).—By feeding cats on flesh free from fat and glycogen, carbon is put on in too large a quantity to be accounted for as glycogen. The opinion that it is present as fat is defended in view of Pflueger's criticisms on this point.

*The Source of Foetal Fat.* By MARTIN THIEMICH (*Chem. Centr.*, 1899, 939; from *Centr. Physiol.*, 12, 850).—The fat of new born children differs considerably in composition. In order to see whether this is due to the mother's diet, one dog during the pregnant period was given a cocoa fat with low iodine number (8), and another linseed oil (iodine number, 120). There was, however, no difference in the composition of the fat of the foetuses.

*Formation of Sugar in Animals.* By MANEO KUMAGAWA and RENTARO MINRA (*Chem. Centr.*, 1899, I. 299).—In starving dogs, injection of phloridzin leads to glycosuria, although such animals had no glycogen and but little fat in their bodies; the sugar must arise from proteid. In another animal, which was fat, the same result followed the injection. The amount of sugar stands in constant relation to the amount of proteid metabolism.

*Formation of Sugar from Proteid.* By RUDOLPH COHN (*Zeit. Physiol. Chem.*, 1899, 211).—It is known that aspartic acid and glycocin, when given to animals, increase the amount of liver glycogen; the present experiments on rabbits show that the same is true for leucine. Now leucine is the largest product of proteid decomposition (50 per cent. in the case of casein). It is regarded as probable that leucine is the source of sugar from proteid a comparison of the formulæ of leucine, and dextrose shows this to be by no means impossible. No complicated synthesis is involved; oxidation, splitting off of the amido-group, and reduction are all that are necessary. The fact that leucine leads to glycogen formation lends support to this view.

*Fibrin Formation.* By OLOF HAMMARSTEN (*Zeit. Physiol. Chem.*, 1899, 98).—By means of repeated precipitations, fibrin-

ogen was obtained almost free from calcium (0.006 per cent). Ferment solutions were prepared from oxalated plasma which contained only 0.00004 to 0.0007 per cent of calcium. On mixing the two solutions, typical fibrin was formed which contained only 0.006 per cent of calcium, or in some cases even less. Fibrin is therefore not a calcium compound of fibrinogen. The small amount of calcium present must be regarded as an impurity, for if it were in chemical combination the molecular weight of fibrin must be greater than 800,000 or fifty times greater than that of oxyhæmoglobin. Quantitative experiments on the relationship of fibrin and fibrinogen showed that from 63 to 83 per cent. of the fibrinogen appeared as fibrin. In some of these experiments calcium chlorid was added, in others not; the difference in the amount of fibrin formed is insignificant; if only a small amount of the calcium salt is added, fibrin formation is rather more rapid; if the amount of calcium salt is increased, the amount of fibrin formed is slightly diminished; in other words, it acts like other neutral salts. The formation of fibrin from fibrinogen is usually regarded as a process of hydrolysis, the fibrinogen splitting into fibrin and fibrino-globulin. Schmiedeberg's equation (*Archiv. exp. Path. Pharm.*, 39) for this would require that only 48-49 per cent. of the fibrinogen should appear as fibrin. The difference between the elementary composition of fibrin, fibrinogen, and fibrinoglobulin is so slight as to suggest that the process is not necessarily one of hydrolysis at all. It may be that it is simply a matter of intra-molecular rearrangement, varying quantities of the altered fibrinogen reappear as fibrin, and part remains in solution as fibrino-globulin. Possibly casein formation is similar.

*Origin of Fibrinogen.* By ALBERT MATHEWS (*American J. Physiol.*, 1899, 53).—The experiments recorded are believed to support the conclusion that the fibrinogen of the blood originates from the decomposing leucocytes, especially of the intestinal area. Fibrinogen increases when the number of leucocytes increases; after removal of the intestine there is little or no renewal of fibrinogen if the animal's normal blood has been previously replaced by defibrinated blood. This is not so when organs other than the intestine are removed.

*Crystallin Fibrin.* By S. DZIERZGOWSKI, (*Zeit. Physiol. Chem.*, 1899, 65).—Maillard has described a crystallin deposit which occurs in phenolised blood serum (ox and horse) when it

is allowed to stand; he termed it crystallin fibrin. The deposit, however, is partly amorphous; and by means of suitable solvents can be separated into four constituents: (1) calcium salts of the higher fatty acids; (2) compounds of these acids with glycerol and cholestrol; (3) proteid matter which is digestible by gastric and pancreatic juices; (4) nuclein. It is the two first upon which the crystallin character of the deposit depends.

*Glycocin.* By KARL SPIRO (*ZEIT. Physiol. Chem.*, 1899, 174).—Glycocin is obtained among the amido-acids which are decomposition products of many true proteids, and not only from albuminoids like gelatin. If this occurs also in the body, glycocin must be regarded as one of the precursors of urea.

*Uric Acid in Mammals.* By OSKAR MINKOWSKI (*Chem. Centr.*, 1899, 212).—Uric acid in synthetic ally formed in the liver of birds; the question investigated is whether mammals have a similar synthesising power. It was found, however, that after administration of large quantities of urea and ammonium sarcosylate, or allantoin, there is in dogs no rise in the amount of uric acid secreted. Feeding on calves' thymus or nuclein from the salmon leads to a rise of the uric acid in the urine; but the nuclein bases do not act in this way.

*Uric Acid Infarcts in New Born Children.* By H. SPIEGELBERG (*Chem. Centr.*, 1899, 211).—The kidneys of children who die during the first weeks of life, show, as a rule, a deposit of urate crystals, the so-called uric acid infarcts. Experiments on dogs show that the adult organism is able to decompose far more uric acid than the young animal. After subcutaneous injection of uric acid in new-born animals typical infarcts are formed. This relationship of the young animal to uric acid is something quite special. With other substances there is no evidence of diminished power of oxidation.

*Excretion of Uric Acid.* By SCHREIBER and WALDVOGEL (*Chem. Centr.*, 1899, I. 849).—Two students fasted for three days. At the beginning of the research, they passed daily 0.477 and 0.718 gram of uric acid respectively, and on the third day 0.197 and 0.205 gram. The amount of uric acid does not run parallel to the total nitrogen or to the acidity of the urine; it does not disappear with vegetable diet. Animal food causes a rise in the xanthin bases, but not in the uric acid excreted, whilst salicylic acid causes a rise in both.



## New Books.

**THE TREATMENT OF PELVIC INFLAMMATIONS THROUGH THE VAGINA.** By William R. Pryor, M. D., Professor of Gynecology, New York Polyclinic; Consulting Surgeon, City (Charity) Hospital; Visiting Surgeon, St. Elizabeth Hospital, New York City. With 110 illustrations. Published by W. B. Saunders, 925 Walnut St., Philadelphia, Pa., 1900.

This work contains an exposition of the personal experience of the author in treating pelvic inflammations through the vagina. An earnest disciple of the French school of gynecologists who, some years ago, began to advocate these methods of procedure, Dr. Pryor, has advanced with and sometimes beyond his teachers, and by dint of long practical experience has been enabled to add some important modifications to the ordinary operative technique. The whole trend of the book is practical, and the pathological conditions met with are not dealt with in detail. One has not to read between the lines to see that the author is in favor of what might be termed an aggressive interference, although he does not omit to lay down rules for palliative treatment in appropriate cases. But be that as it may, it must be acknowledged that Dr. Pryor states clearly the class of cases he deems appropriate for treatment by the vaginal route, and moreover goes into all necessary detail as to the procedure to be employed. The book is intended for the general practitioner, but to appreciate its thoroughness the reader should certainly be well up in gynecology. Though relying in most cases upon the abdominal route in dealing with cases of pelvic inflammations requiring radical procedures, we have nevertheless found the vaginal method as advised by Dr. Pryor in occasional instances to give excellent results. The whole question is certainly of sufficient importance to warrant a work devoted especially to its consideration; and in Dr. Pryor's book we have a fund of information which can be turned to practical use both by the general practitioner and also by the gynecologist.

HUNTER ROBB.

**AN EXPERIMENTAL RESEARCH INTO SURGICAL SHOCK.** An Essay awarded the Cartwright Prize for 1897, by Geo. W. Crile, A. M., M. D., Ph. D., Professor of the Principle of Surgery and Applied Anatomy in the Cleveland College of Physicians and Surgeons, etc. 8 vo.; pp. 160. J. B. Lippincott & Co., Philadelphia, 1899.

No practitioner who is doing surgical work can afford to be unfamiliar with the results of Dr. Crile's painstaking and accurate work on the nature of surgical shock and how to prevent

it. Especially valuable are his exact determinations of the noli-me-tangere regions of the body, the inhibitory reflexes of the larynx, which cause death by arrest of respiration, explaining those little-understood accidents following intubation and sometimes tracheotomy; the embarrassment of respiration following rough dissection about the axilla; the prompt depression following pulling on the pyloric end of the stomach or roughly handling the region thereabout, etc. All these things have a direct bearing not only on the method of operation to be followed, but often on the choice of operation as well.

TUCKERMAN.

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MASSAGE AND THE ORIGINAL SWEDISH MOVEMENTS, THEIR APPLICATION TO VARIOUS DISEASES OF THE BODY. By Kurre W. Ostrom, from the Royal University of Upsale, Sweden. Fourth edition; pp. 168. \$1.00 in cloth. P. Blakiston's Son & Co., Philadelphia, 1899.

A more general knowledge of massage and the treatment of disease by movements passive and active, is a desideratum. It would do much to take the wind out of the sails of osteopathic quackery. These courses of lectures delivered by the author before various training schools for nurses are good reading for the practitioner. It were better if such courses were not confined to classes of nurses, but were made a part of the regular curriculum of the schools of medicine.

TUCKERMAN.

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A REVIEW OF RECENT LEGAL DECISIONS AFFECTING PHYSICIANS, DENTISTS, DRUGGISTS, AND THE PUBLIC HEALTH, TOGETHER WITH A BRIEF FOR THE PROSECUTION OF UNLICENSED PRACTITIONERS OF MEDICINE, DENTISTRY OR PHARMACY, WITH A PAPER ON MANSLAUGHTER, CHRISTIAN SCIENCE AND THE LAW, ETC. By W. A. Purrington, of the New York Bar, Counsel for The Dental Society of the State of New York, etc., pp. 105; 50 cents. E. B. Treat & Co., New York, 1899.

This book will interest medico-legal students, as it summarizes up to date the legal decisions affecting practitioners of medicine and surgery.

TUCKERMAN.

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A PRACTICAL TREATISE ON MATERIA MEDICA AND THERAPEUTICS. By Roberts Bartholow, A. M., M. D., LL. D., Professor Emeritus of Materia Medica, General Therapeutics, and Hygiene in the Jefferson Medical College of Philadelphia, etc. Tenth edition; 8 vo; pp. 866. D. Appleton & Co., New York, 1899.

Following the general plan of the previous edition Dr. Bartholow has brought his work up to date in the present one. With the same conciseness and practicality which has characterized his discussion of the older remedies, he takes up the indications and contra-indications relating to all the newer synthetic

remedies which have survived in use long enough to get fairly beyond the boom-advertisement stage. In the present edition he has added a concise chapter on prescription writing, which adds considerably to its value as a text-book for students.

TUCKERMAN.

ATLAS OF DISEASES OF THE SKIN, INCLUDING AN EPITOME OF PATHOLOGY AND TREATMENT. By Prof. Dr. Franz Mracek, of Vienna. Authorized Translation from the German edition, by Henry W. Stelwagon, M. D., Ph. D., Professor of Dermatology, Jefferson Medical College, Philadelphia. With 63 colored plates and 39 full-page half-tone illustrations; pp 199. W. B. Saunders, Philadelphia, 1899.

This number of the series of medical hand atlases issued by the same publishers is a convenient reference-book for the busy man. The plates are clear and show the characteristic features of the various diseases as well as plates can. The epitome of treatment given with each disease is brief, but comprehensive enough for all practical purposes. We miss a plate or so illustrating the eruption of variola and the points which differentiate it from varicella, a matter of considerable importance as variola becomes rarer and less often seen by the physician in general practice. Doubtless the omission will be supplied in the subsequent editions.

TUCKERMAN.

HAY FEVER AND ITS SUCCESSFUL TREATMENT. By W. C. Hollopeter, A. M., M. D., Clinical Professor of Pediatrics in the Medico-Chirurgical College of Philadelphia, Pa. Second edition; pp. 151; cloth \$1.00. P. Blakiston's Son & Co., Philadelphia, 1899.

Dr. Hollopeter maintains that hay fever is curable in a large majority of cases, without change of climate, by thorough anti-septic treatment of the naso-pharynx combined with proper constitutional regimen. Complete details of the method are given in the book.

TUCKERMAN.

A COMPEND OF GYNECOLOGY. By William H. Wells, M. D., Adjunct Professor of Obstetrics and Diseases of Infancy, Philadelphia Polyclinic, etc. 2nd edition. P. Blackiston, Son & Co., Philadelphia.

With large books, so with small ones, some are not worth investing in, while others, whether it be for reference, or study, are well deserving of a place in the physician's library or on the office table.

The compend under review belongs to the latter class. It is



well written, profusely illustrated, and is fully up to date; a veritable *multum in parvo* on the subject with which it deals. C.

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**TREATMENT OF FRACTURES.** By John B. Roberts. A. M., M. D., Professor of Surgery in the Philadelphia Polyclinic, Mutter Lecturer on Surgical Pathology of the College of Physicians of Philadelphia. With thirty-nine illustrations. Price \$1.50. D. Appleton & Co., New York.

In reality a collection of essays by the above author re-written to express his present views, and to fit this issue. The book is well written, and Dr. Roberts does not hesitate to condemn many modern and all intricate surgical appliances for the treatment of fractures, while he most justly advances the adoption of only the simplest apparatus combined with the surgeon's own mechanical ingenuity. In the compilation of a work of this kind many of its topics must be regarded as perhaps old and familiar, even when re-written from a borrowed construction; but less of this will be found in the above little work than in most books of its size, while the chapter on "Subcutaneous Nailing in Fractures with Unusual Tendency to Displacement," must be considered as comparatively a new departure in the treatment of fractures involving joints. Nothing tries a practitioner's love for his profession more than to have his best efforts in the care of "joint fractures" only too often crowned with utter failure and legal complications. Subcutaneous nailing alone oftentimes (according to the author), or, better still, in connection with the skiagraph, offers a solution to the above unpleasant fact inasmuch as the fracture lines can be seen and reduction maintained by a direct method of fixation. Many other procedures as valuable as the latter are set forth, and all through the work the author proves his assertion made in the preface that, "Independent thinking leads to the abandonment of false theories." STEPP.

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## Society Proceedings.

May L. Bassett, Medical Reporter.

CUYAHOGA COUNTY MEDICAL SOCIETY, DEC. 7, 1899.

The regular meeting of the Cuyahoga County Medical Society was held at the Cleveland Medical Library on the evening of Dec. 7th, the President, Dr. Bunts, in the chair. The minutes of the last meeting were read and approved. The name of Dr. Frank W.

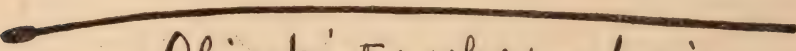
Hickin was proposed for active membership and the Secretary was instructed to cast the ballot of the society for his election. A letter from the Secretary of the Detroit Medical and Library Association, asking for action of the society with reference to interstate reciprocity in the matter of licenses to physicians was brought before the society. Dr. Tuckerman mentioned the fact that the committee of the State Medical Society had incorporated this feature in the bill for medical legislation which will soon come before the legislature. On motion the society voted to indorse the action of the Detroit Medical and Library Association and advise them of the section of bill mentioned by Dr. Tuckerman.

Presentation of cases followed.


#### STRICTURES OF THE ESOPHAGUS WITH A DEVICE FOR THEIR DILATATION.

*Dr. Tuckerman:* The case which I present this evening is one of stricture of the esophagus. This man is 64 years old and has always been a hard working man, having been in a foundry all of his life. Until the first of last April he had never been ill but once and that was some thirty-five years ago, when he had an attack of jaundice. It was so severe as to disable him for some time. Last April he noticed a pain and soreness which he referred to the region of the depression of the clavicle on the right side of the neck. This was quite severe for a week or so, but passed away at the end of that time. After the soreness disappeared he noticed a difficulty in swallowing. This became worse gradually during the summer, and on the 19th of August he came into my office in a considerable degree of excitement, stating that he had a piece of meat in his throat and he could not get it up. This was in the evening and he had taken this meat at dinner. He claimed that he had chewed it finely, but insisted that he knew it was the meat and that it had stuck in his throat. I passed an olive tip whalebone bougie down to the obstruction, and this is the specimen that I dislodged. It is a tough piece of meat,  $2\frac{1}{2}$  inches long and about an inch wide. On examination of the esophagus with the bougie after the piece of meat had been dislodged, I found that at a distance of seven inches down there was a three-fold stricture through which I could pass only the smallest sized tip of the esophageal bougie. It measures 27 Fr. After passing the lowest band the bougie could be carried without difficulty into the stomach itself. He was instructed to come for regular treatment, but came only when the great difficulty which he had in swallow-


ing returned. That was once or twice during the next few weeks, and he had the bougie passed each time. Finally he ceased coming and I did not see him for a long time, not until he again had extreme difficulty in swallowing and a piece of meat had again become lodged above the stricture. I could not get the bougie past this time, but I must have moved the piece somewhat from its firm position, for it dislodged itself in two or three hours. The same thing happened to him again on Thanksgiving day, only this time it was a small piece of turkey that lodged. There is no evidence of any cachexia or anything carcinomatous about the condition of the esophagus, no enlargement of the glands or any nodules about the neck which would indicate that the stricture is of malignant character, but if he goes about so long without any dilation of the passage, it closes tighter and tighter until he can hardly swallow even liquid food. My idea of the pathology of the case is that he had abcess of some of the deeper glands which ruptured into the esophagus, and the stricture has resulted from cicatricial contraction of the fistula. There is no account of his swallowing anything that might irritate the tract and the history of the case is absolutely negative aside from this soreness. It is puzzling sometimes to know just what to do in the matter of dilation. There are so many forms of dilators, and none of them wholly satisfactory. I saw these Wales bougies when I was in at Hessler's one day, and it occurred to me that by stringing one of



*Olive-pointed whalebone bougie*



*Wales bougie.*



*Combined bougie*

them on the ordinary whalebone esophageal bougie I could get whatever amount of dilation the patient would tolerate, the olive tip serving as a guide. I will now show you these strictures, which I can do very easily, and you can see plainly the passage



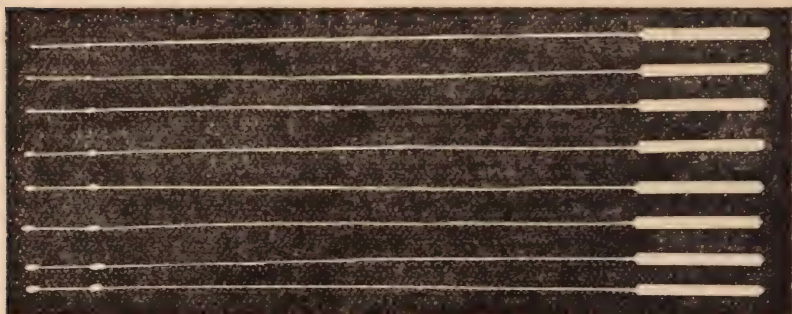
of the dilators. The largest one I have succeeded in passing is a number five, which measures 45 Fr., and after the passage of that he feels better for several days, and does not come back until he has a marked return of the trouble in swallowing. I will now pass the dilators. There seems in this case to be a distinct pocket at the point where you can feel the resistance during the effort of swallowing. You have to alter the direction of the instrument at that point to get it past the obstruction.

*Dr. Corlett:* How long does he obtain relief after the dilatation?

*Dr. Tuckerman:* About a week. You can see as the olive tip passes there are three distinct points of resistance in the space of from 1 to 2 inches, and you can see how readily the larger dilator passes guided by the whalebone stem. I do not know but someone has used this combination before, and if I am showing someone's old device I shall not be troubled by it, for I am making no claim of priority. This device is simply a standard instrument combined with another to make an instrument with which you can dilate the esophagus to any size desirable. The Wales bougies run from 27 Fr. upward. In connection with this case I wish to report another one in which I used the Wales bougie without a guide. It was that of a woman, some 30 years, and the stricture was supposed to be at the cardiac orifice of the stomach with dilatation above, but no positive location of it had been made. The passage of a bougie showed a stricture about the same distance down as this one, and through which nothing larger than this olive-pointed bougie, 30 Fr., could be passed at first. On withdrawing it I found the heel was covered with blood, showing that there was an ulcerated band. In that case, however, there was a complication of entire absence of hydrochloric acid from the stomach. She had been using the stomach tube for two or three years, finding comfort after its use. Though she had considerable distress after eating, the stomach emptied itself freely, showing that there was no abnormal resistance at the pylorus. The stricture was seven and one-half inches down, annular in character, and I used Wales bougies from 30 Fr., up to No. 8, i. e. 60 Fr., giving the patient one of the latter size to pass occasionally herself. Now it looks as though this large bougie would find considerable difficulty in going down, but the patient ordinarily makes less fuss about swallowing a point like this than an olive point where there is but a single band to the stricture. These bougies are not long enough to reach through the cardiac orifice

into the stomach, and I have suggested to the instrument makers that they would do well to make them four or five inches longer, and then they would be available also for strictures anywhere in the esophagus, and by gradually increasing the size the dilation can be carried to any degree desirable.

*Dr. Bunts:* On the question of strictures of the esophagus, I wish to say that I have had a good deal of experience in the last few years with such cases, but very few of my cases have been those of adults—they have been mainly cases in children. All of them have resulted from the drinking of lye and the strictures have been so small that I have never been able to get such a bougie as this through them. I think it important, however, in these cases as in cases of stricture of the urethra to begin with as large a dilator as can be passed through, but in these cases which I have mentioned I have frequently been able to use nothing larger than a filiform bougie. I think we have in such cases an annular stricture which extends along the tract. In the case of children I have found that when I had improved the conditions sufficiently to pass a No. 28 bougie the dilation was all that was required. The passage of a No. 6 or 8 has always been enough to give temporary relief so far as swallowing fluids was concerned. This case seems to me to be a rather unusual one because the



stricture dilates so readily and contracts so rapidly. I question whether cicatricial contraction could be responsible for a stricture which can be dilated so readily. Such a stricture might result from something pressing upon the esophagus from without, and if such were the case we could easily understand that pressing the growth widely away, or whatever obstructs the passage, might give relief for a few days, and then the growth would come back to its old position. I have devised a set of bougies for

smaller strictures but not for one of this size. A No. 30 is probably the smallest size that can be gotten at the stores here and I was obliged to have the ones made which I am using.

After passing the filiform bougie I next pass a whalebone bougie about a No. 3 or 4, and when it is dilated to this extent I am usually able to insert the first of my series of graded bougies, beginning with the No. 6. These dilators are so arranged that all bougies have two olive form bulbs at a distance of  $1\frac{1}{4}$  inches apart, the smaller bulb being at the tip and the other bulb is one size larger. The next dilator begins with this large size, and the second bulb is increased one size. Thus, upon the first dilator we have number 6 and 7 and on the second dilator number 7 and 8, and on the third 8 and 9. If the first bulb succeeds in passing a stricture it is usually safe to use a little additional force necessary to pass the second one.

I cannot understand why he should have such trouble in swallowing. I had a case of stricture of the esophagus, following a swallowing of lye, who was sent to the hospital for an operation for gastrostomy, the patient being unable to swallow water, and suffering intensely from thirst and hunger and being greatly emaciated. After much difficulty I succeeded in passing a long filiform whalebone bougie. Following this I succeeded in dilating it to No. 6. He was so pleased at being able to drink milk and water that he considered himself practically cured and left the hospital without permission. In a few days, however, the stricture again closed and he was unable to swallow fluids. This time he submitted to gradual dilatation until a No. 26 was reached. He again refused to continue treatment and has satisfied himself by passing a bougie himself from time to time. He has gained in weight until he now weighs in the neighborhood of 200 pounds and seems to be in perfect health.

*Dr. Tuckerman:* I am very much obliged to Dr. Bunts for his remarks upon the case. Of course there are strictures and strictures, and you have to adopt your means to the character of the stricture. The cases that have fallen under Dr. Bunts' observation have been of one class and his device has admirably fulfilled the indications he was confronted with. Those I have happened to meet have been of another character, and the device I have used seems to be effective. This man has been unable to swallow anything solid since the first attack which he had. A piece of meat the size of the end of my little finger will stop in his



throat until dislodged. Everything that he eats must be very soft else he cannot swallow it. It feels to me as though there must be a pocket just above the lower stricture. Each time after a dilatation he will go a week or so without treatment, and then he gets where he cannot swallow liquids even. This bougie, No. 5, 45 Fr., is the largest one I have ever passed, and it requires a good deal of force to push it through the lower stricture.

*Dr. Stuart:* The case which I present to-night is that of a little girl of 5 years. She has been attending the clinic of Lakeside Hospital for four or five months with an interstitial keratitis. Its origin is obscure, but it is probably due to an inherited specific trouble. She has been on bichloride treatment during this time. One peculiar thing about the case is the fact that there is a great deal of vascularization of the cornea. The mother attended the clinic two years ago and at that time had paresis of the internal rectas muscle of the left eye, but her eye muscles are now normal. Whether this bears any connection with the present difficulty of the child is a question. I should have mentioned that the child's teeth are quite notched. In connection with this case I wish to mention another which we have in the clinic which exhibits this same peculiar feature of vascularization.

I will present a drawing of a case for Dr. Bruner, as he is unable to be here. It is a specific iritis, but occurring in the secondary stage known as gummatous iritis. The first symptoms of infection appeared at 29 years of age and yielded very readily to specific treatment. When seen in the clinic about a year ago there was no appearance of the papule or any nodule whatever and the vision was as good as in the other eye.

Here is also another drawing of a case of specific iritis; a young man, and the case was seen early, but posterior synechia had already taken place. It was at first a doubtful question whether this might not be a sarcoma of the iris, but under specific treatment it yielded readily. A few synechiae now remain, but otherwise the eye is all right.

*Dr. W. T. Corlett:* Not being informed as to the order in which the cases of syphilis were to be presented to-night, I have endeavored to present the various stages of the disease in its most striking clinical forms.

The case of chancre of the tongue, which I intended to show, has unfortunately failed to appear. We have, however, a case that presented himself yesterday for treatment, illustrating what

may be called "the dawn of syphilis," or its first appearance after the initial lesion. In his case the initial lesion has completely passed away, as no evidence of it can be found. This is uncommon in the male, although from the anatomical conformation of the genital organs, not so uncommon in the female. Further, in this case even a history of chancre cannot be obtained, and the patient denies all knowledge of having contracted the disease. He first noticed pain in the mouth, and tenderness on mastication, which was soon followed by redness, much as you see it to-night. You will first notice that the lesions occurring on the mucous membranes are farther advanced than those appearing on the skin. This in my experience is the rule. It will be observed further that the general erythematous rash invades the whole body surface. The superficial lymphatic glands are likewise enlarged equally over the various regions of the body where they can be felt. The case is of interest, first, because of the apparent absence of any initial lesion; second, because it presents the distribution of the early syphilide in its most characteristic way; third, at this stage there is no excuse for being mistaken in the diagnosis.

Just a word at this time about the early diagnosis of syphilis. From experience I have become gradually convinced that this is the most important epoch in the history of syphilis because of the liability of a mistaken diagnosis. I hold it to be impossible to make a positive diagnosis in all cases from the initial lesions alone. There are cases with typical induration, followed by the typical enlargement of the first chain of lymphatic glands, with a clear history as to time of exposure and subsequent development, when one may with absolute certainty recognize the nature of the disease from the initial sore. Frequently, however, the history is not trustworthy, the clinical picture may be masked by extraneous conditions, and the subsequent induration of both chancre and lymphatics are not sufficiently distinct to warrant one in determining, when the subject is of such vital importance. For years, therefore, I have taught and practiced waiting until the development of the disease enables me to form a positive diagnosis. Neither is the time thus spent wholly lost, for with tonics, such as iron and the vegetable bitters, we can often place the patient in a more suitable condition for recovery than by resorting to mercury the first time he presents himself. So frequently do we encounter those who are laboring under the impression that they have been infected with syphilis—veritable syphilomaniacs. In

some instances years have elapsed and a history as to the conditions which first appeared may not always be easily obtained. Such patients have great apprehension lest the disease which they have been led to believe they were suffering with might break out afresh, or infect their family. Again, I have not infrequently met with patients who have been almost under the constant care of one physician or another for many years, in which a positive diagnosis evidently never had been made. Infinitely better is it to wait until, if necessary, the secondary eruption of syphilis appears before instituting any therapeutic measures that will mask the landmarks of the disease, and thus render a diagnosis for all time more or less a matter of uncertainty.

The treatment to be recommended in early syphilis depends largely upon the patient. In this man, who is strong and robust, the bichloride of mercury, beginning with 1-25th of a grain three times a day, and gradually increasing until 1-16th, or even 1-10th, is reached, will be found to answer best. In more delicate persons, those who are confined within doors, and in women, a milder form of mercury is to be preferred. Calomel, one-fourth to one-third of a grain, answers well, and in children, the mercury with chalk is the drug best suited to this stage. Mercurial inunctions likewise are to be recommended in certain cases where practicable, and finally, the intromuscular injection of mercury (mercury salicylate grs. i, paraffin-oil grs. ix, of which a Pravaz syringe full may be injected every five days) is the most rapid means we possess in controlling the disease. Thus, with alarming eye complications, or when the ravages of the disease warrant energetic measures, the intromuscular injection should be resorted to. Seldom do we find it necessary to institute any special treatment for the initial lesion, neither is it necessary to direct especial attention to the lesions occurring on the skin or mucous membranes.

The second case is that of a woman, aged 63 years, who presented herself at the out-patient department of the Lakeside Hospital one month ago, with this lesion at the base of the nose, which had existed for about a year. It was entered as a probable case of epithelioma. This snap-shot diagnosis was somewhat strengthened by the history and casual appearance of the lesion. The family history is good. She is a mother of seven grown-up children, who are all living and enjoying good health. The patient states that she never has had any previous eruption, neither has



she had falling of the hair or soreness of the throat at any time. She finally maintained, upon entering, that the lesion at the base of the nose was the only one she had ever had. Upon further inspection it was found to be elevated above the surrounding skin with a distinct basin-like rim. No abrasion of the surface was present, and it presented a dark-red or bluish color. Upon palpating between the thumb and finger a distinct induration could be detected. There was no pain especially complained of. I had no opportunity of examining the case before presenting it to the class, and took occasion to mark the various diseases to which it bore the closest resemblance. First, epithelioma, or rodent ulcer; second, *mucosus fungoides*; third, indurated erythema; fourth, *lupus vulgaris*; fifth, syphilis. All lesions occurring after middle life which are slow to heal must be regarded with suspicion. Such lesions may have a harmless appearance, may proceed for months and even years, until finally active degenerative changes ensue, which stamp them as indubitable pictures of epithelioma. The absence of other lesions co-existent on other parts of the body, tended to confirm the supposition that the case might be one of epithelioma or rodent ulcer. The color of the lesion, dark red with a purplish tint, militates against this supposition. The absence of pain, the absence of any abrasion, during its whole course likewise weakens the force of this supposition. It was remarked at the time that if we were unable to obtain further light it might be found necessary to resort to a microscopical examination.

As to the second disease, *mucosus fungoides*, the single lesion present, as well as the history given by the patient, enables us to exclude this disease. Further, the clinical picture is not that of *mucosus fungoides*, although one should bear such a possibility in mind.

Third. Erythema induration is a evanescent disease, while this has existed for a year without material change.

As to the fourth disease, *lupus vulgaris* is essentially a disease of youth, and presents a tubercular or nodular appearance, instead of the flat, elevated margin here so well defined.

The suggestion made by one of the class that the patient's positive statement that no other lesions existed, might be interpreted to mean that such lesions did exist, was not without application in this particular case, for upon questioning the patient still further in my private room she admitted having had a slight

mosquito-bite on the the arm, which had become gradually aggravated. Upon examination, a typical syphilitic lesion on the forearm was found, encrusted and discharging foul-smelling pus, which left no further doubt as to the nature of the disease. Here then is a patient, honest so far as her knowledge goes, as to the history given, desirous of aiding in clearing up the mystery, yet giving statements entirely contradictory to the facts as we know them to be. It demonstrates most forcibly the necessity of inspecting the whole surface in the diagnosing of obscure lesions of the skin. She was given the potassium iodide (5 grains three times a day), and upon her next visit both lesions were found greatly benefitted. To-night, as you see, the lesion upon the forearm has well nigh healed, while the induration has nearly disappeared from the one at the base of the nose. I may say further, as to the treatment in this case, that the proportions of iodine will be continued until all symptoms disappear, after which recourse will be had to mercury, for I believe mercury alone possesses the property of eliminating the syphilitic poison. Not all cases, however, are benefitted by either iodine or mercury, and I believe most emphatically that there is no routine treatment for syphilis, either in its early manifestations or for the late lesions such as we have here. Seldom do I give the so-called mixed treatment—that is, the iodide of potash and mercury. Mercury is the drug to be relied upon during the so-called first and second stages. Iodine is used during the third stage to stimulate repair of structure, while mercury must still be given to eliminate the syphilitic poison. It is asked how long mercurial treatment should be continued. In this case I shall advise the continuous administration of mercury for one year, after which it may be discontinued and the further progress of the infection watched. Is syphilis curable? Yes, in the majority of cases. In fairly robust young subjects, with care and proper treatment, one can confirm that in the vast majority of cases the disease may be entirely eliminated, that such persons will never again suffer from any of the effects of syphilis, and that offspring will not in any way be injured from its poison. On the other hand, there are a certain number of cases in which the syphilitic poison acts with extreme severity. Others in which the drugs usually potent in controlling the poison, possess but a feeble curative effect. Again, in cases like the one before us, in which treatment has been wholly neglected and the disease has been allowed to run its course, and while as we

know it may eliminate itself, yet the sequelae of the disease are prone, yes, almost certain, to occur. Can the patient before us be told with any assurance that the disease may be entirely eliminated? No. We can control the symptoms and it may be the patient will enjoy robust health and even die of old age, the syphilitic poison still lurking in her veins.

*Dr. Corlett:* In reply to the question as to secondary infections, I wish to say that they are extremely rare. Undoubted cases have occurred, reported by careful observers. On several occasions it has been my good fortune to watch the effect of the syphilitic virus on a subject already syphilitic. The following observations have been made: When such inoculation takes place during the first three or four years of the disease, little or no effect is produced, excepting in producing a lesion at the point of inoculation, which appears about the end of the fourth week. It does not, however, develop into a typical chancre, induration takes place only to a limited extent and the sore usually disappears within a few weeks without causing any special disturbance. Later, say ten or fifteen years after the first syphilitic infection, the second inoculation appears much like a typical Hunterian chancre, with induration and, in some instances, an induration of the first group of lymphatic glands. Seldom does the process go farther. Again, in rare instances mild syphilis may occur a second time in the same individual. The subject has been a popular theme for discussion at numerous international meetings. There are many who deny the possibility of secondary infection, while others with equal vehemence maintain that such occurrences are not infrequent. The case mentioned as recorded by Bumstead, is not now regarded as an indubitable instance of second infection.

The third case which I desire to present (this evening) is that of a young man, aged 28, in robust health, with a late broken-down gumatous syphilide. The case is of interest because of the limited number of lesions, the only ones being those over the region of the scapula, three in number. The first appears as a deep ulcerated or punched-out excavation, the other two are smaller, but present the same punched-out appearance. No other disease with which I am acquainted produces lesions similar to these. Yet the general surface of the body is remarkably free, neither can scars be detected resulting from former eruptions. According to history given, the disease was contracted nine years



ago. The patient further states that he was treated three years, and from the description given the administration of mercury is highly probable. In this case it may be of interest to say that at the City Hospital, during the past few years, we have had many opportunities of studying the effect of syphilis in some of the old soldiers of the rebellion, who contracted the disease in service thirty odd years ago. These cases for the most part received treatment for four to six or eight weeks, made an apparent recovery, and were discharged to follow their duties in the field. Many of these cases, so far as I am able to determine, have received no subsequent treatment. In some a history has been obtained of certain eruptions, probably syphilitic, which have occurred ten, fifteen, or twenty years after the contraction of the disease, but usually of a mild nature, passing away either with or without treatment. Still others, who had enjoyed complete immunity until a short time previous to their entrance into the Hospital, when the various late manifestations of syphilis appeared. The fact is of prognostic importance. Consider the meagre treatment received and the long period of immunity that these subjects have enjoyed, begetting healthy families, and now as old age approaches, they show only in a mild degree the syphilitic taint. The treatment received at that time evidently was mercurial, as many give a history of having had sore mouth while using certain pills prescribed by the surgeon. All this goes to prove that one may contract syphilis, live to a ripe old age, beget healthy children, suffer no inconvenience and die at the allotted time without the latent poison ever showing itself.

The fourth case is that of a negro who entered Lakeside Hospital eight days ago. He is 46 years of age, and the history obtained shows that the initial sore was contracted four years ago. The beginning of the present difficulty dates from last summer when the soreness of the back was complained of, followed by swelling of the testicle. This subsided, but was followed by swelling of the left inguinal gland, which became enlarged and finally suppurated. He bears marks of having had an incision. About the same time an eruption appeared which you now see whitish in color, because an eruption red in the Caucasian assumes in the negro a whitish or fawn color. This eruption appeared on the thighs and posterior and anterior parts of the legs. Gradually extensive ulcers formed, as you now see. The case is one of semi-malignant syphilis. Many of these cases

do not respond to treatment and the death rate is extremely high among them. Especially is this the case when contracted after 40 years of age, and in strumous or otherwise debilitated subjects.

Finally, I wish to exhibit certain photographic illustrations of syphilis which are of interest at this time. The one which I now show was taken from a woman, aged 35, who entered my service at the Lakeside Hospital a few months ago with syphilitic rupia. This is the most striking case I have ever seen in America. It may be well to add that rupia is of rarer occurrence than formerly, probably because of the improved methods of treatment now in vogue.

The second photograph illustrates a late syphilide, resembling to a certain extent the fourth case reported, in which the lesions bear a striking resemblance to a bromide eruption. Dr. Lowman, who is present, will remember a case of bromide eruption which we had the opportunity of observing more than fifteen years ago. I regarded the case as syphilitic, and although measures usually successful were ineffectual, I still persisted, feeling sure of the diagnosis. The case finally passed out of my hands and was treated by Dr. Lowman. He seeing the futility of anti-syphilitic measures gave him tonics, mineral acids, etc., to the great relief of the eruption, which, under this treatment, well-nigh disappeared. It did not occur to me until too late that the patient had occasional attacks of epilepsy, for which he was in the habit of taking a patent medicine evidently containing one of the bromides. Our failures, I believe, are more potent factors in our advancement than are our successes. I never have forgotten the picture presented by this first case nor the subsequent history of the disease.

The next photograph is one of malignant syphilis taken many years ago. The patient, a male, aged 60, in which the disease was unusually severe and terminated fatally during the first year.

The next photograph is one of epithelioma, in which a differential diagnosis between syphilis and epithelioma gave us some difficulty, until finally a report made by Dr. Perkins, of the Pathological Laboratory at Lakeside Hospital, threw further light on the subject.

The next photograph likewise might be taken for either an epithelioma or syphilis. The history furnished was also misleading. But its rapid course and development, in an otherwise

healthy subject, led us to regard it as syphilitic and adopt a treatment under which it rapidly disappeared.

*Dr. Kelley:* In regard to this case of which Dr. Corlett has spoken—I recall it distinctly, although it occurred ten or twelve years ago. It was very peculiar. The eruption was unusually extensive, large bullous. Such a case, if syphilitic, one would expect to have fatal termination. There were pockets formed as large as a half dollar over the legs and feet, and these afterward formed heavy crusts and piled up in masses together. The patient is still living. As bearing upon the diagnosis of this case, which I did not feel satisfied was syphilis, I may state that a couple of years afterward the child's father had a peculiar attack which seemed something like angina pectoris, but with more dyspnea than pain. Dr. Vance and I looked him over very carefully, and Dr. Vance concluded that there was some syphilitic change in the blood vessels of the heart. We never could get any family history that was definite. The boy is now grown and apparently well.

*Dr. D. B. Hanson:* I am very much pleased to hear Dr. Corlett remark that he did not treat syphilis until he was made sure of his diagnosis by the appearance of secondary lesions.

I formerly thought I could diagnose this disease by the classical primary ulcer, but so many cases failed to develop the secondary manifestations that I made up my mind that I was filling up my patients with mercury when it was not indicated. As I would not care to be treated that way myself I discontinued that method with my patients. Secondary lesions, I am sure, are less plain when modified by treatment before they appear.

I think it quite remarkable that so many tertiary cases deny ever having any primary or secondary lesions. I remember one case of a very intelligent man who went blind from syphilitic iritis who absolutely denied all previous manifestations.

The more I see of this disease the more sure I am that a reliable diagnosis can not be made from the appearance of the primary lesion alone.

*Dr. Baker:* Dr. Stewart's case is an interesting one. If I were asked what is the most characteristic sign of congenital syphilis, I should answer interstitial keratitis. In such a typical case as that presented to the society to-night it is not necessary to even ask the history of the parents. Interstitial keratitis comes on usually from four to twelve years of age, although I



have a case now under observation, of a young man twenty-eight years of age, which is very unusual. In the three or four cases of adults that I have met previously I have noticed as in the present one, that they recover much more quickly than children.

Some time since I took the trouble to examine the literature of the subject and I found this was also the experience of other observers.

I believe the profession is not as careful in making diagnosis of hereditary syphilis as it should be. Indeed, I believe that more errors are made in making a diagnosis of hereditary syphilis when it is not present than otherwise. I believe that children either have syphilis or have not, and that there is no such thing as a syphilitic taint appearing as eczema, scrofula and ricketts in the third and fourth generation. My observation has been that children are not born with syphilis, as we have all been taught. Indeed, I myself have never seen an infant born with a syphilitic eruption.

*Dr. Lowman:* How about pemphigus?

*Dr. Baker:* Well, that, as Jonathan Hutchinson says, is a very perplexing exception. The history I get is this: The child is born plump, fat, clean and well. At the age of two or three months it begins to suffer from snuffles, loses weight, eruptions appear and present all the well-known characteristics of infantile syphilis. If the child survives, at the end of a year or two it again becomes quite well and enjoys good health for several years, when it again begins to suffer from symptoms corresponding to tertiary lesions. Among these, one of the most constant and characteristic, is interstitial keratitis, also frequently accompanied by effusions into the larger joints. A few years since, at one of my clinics, I presented three of these cases of interstitial keratitis, all of whom were suffering from a large knee.

Many of these patients also suffer from deafness. In fact, if a child or young person without previous otorrhea, earache or injury becomes deaf suddenly, the probabilities are it is of syphilitic origin. The other evidences of hereditary syphilis, such as malformation of the teeth, peculiar form of skull, earthy pallor of skin, pitted with scars especially around the mouth, are too familiar to need mention.

As to the treatment, there is no question as to the benefit of iodide of potash, but it must be used carefully with children. They can not take large doses or even small doses long contin-

ued. As in acquired syphilis, the main reliance must be upon mercury, and fortunately children take kindly to it.

*Dr. Kelley:* This is too large a subject to more than touch a point or two. I would like to ask Dr. Stewart—In the case of the little girl he has presented, whether she has her permanent teeth yet. If she is only between four and five years it is rather early for her to be showing her permanent teeth. As bearing upon the question of syphilis it does not amount to much if these are only temporary teeth. They may come early or decay early in syphilis, but this is not pathognomonic. In regard to the treatment, the doctor spoke of bichloride being used right along; it does not seem to me that in these cases of keratitis, that they clear up as promptly under its use as under potassium iodide besides mercury.

The fact that the iodide will cause lesions to disappear without really eradicating the disease may ordinarily be a great objection to its use.

But diseases of the eye are so distressing and unsightly they should be cleared up as soon as possible, even if the disease should possibly appear somewhere else upon the patient, which may be prevented by the continued use of the mercury. Mercury alone will clear up the early manifestations of hereditary syphilis, which correspond to the secondaries of acquired syphilis; but when you come to the later manifestations, which correspond to tertiaries, iodide is necessary.

*Dr. Reich:* I know it is claimed by some that the poison of syphilis travels so quickly through a patient's system that even if the initial lesion could be cut away immediately upon infection, it would have no influence upon the course of the disease, while others claim the opposite. I have thought that perhaps the patient would not suffer so long from the disease, nor the poison in the system be so great. I should like to know what Dr. Corlett can tell us in regard to this point. I would like to remark again, as some of you will remember I did at the last meeting, that the giving of mercury immediately upon the lesion being discovered is not wise. Many great clinicians here, and especially in Europe, do not give mercury when the lesion is first seen. If you do this the patient is liable to become immune against the drug, and then when the patient gets secondary syphilis the mercury will not have the effect it would otherwise. Therefore, most physicians prefer to wait until the secondary infection appears.

I remember of being told not to be in a hurry to begin syphilitic treatment when first finding the primary eruption. It may be a chancroid, or it may be chancre. Wait, and make sure that you have a true syphilis, and then give your mercury and iodides.

*Dr. Bunts:* I would like to ask Dr. Corlett whether a mother who has inherited syphilis can transmit it to her offspring provided the father has syphilis?

*Dr. Stuart:* With regard to the question asked of me by Dr. Kelley I shall have to say that I am not informed as to whether the teeth are the permanent ones or not, as I failed to ask whether they were of the first or second eruption. As to treatment, I can say that the child in addition to other treatment is getting some of the forms of iron. In Dr. Baker's remarks upon interstitial keratitis, and the question of its heredity, I call to mind the fact that we have now in the clinic a young woman who has a very marked interstitial keratitis, with vascularization of the cornea. The striking feature of the case is that she had had a brother and two sisters at the clinic some years before this with the same condition. We have never seen the father or mother, however. I think the early clearing up of these cases is important. Long-continued cases of keratitis develop almost invariably a nystagmus. I am not prepared to say that this may not be due to the continued use of the mydriatic.

*Dr. Corlett:* I have little to add excepting to express my pleasure in the very able and instructive paper presented by Dr. Sawyer. Neither can I offer any further testimony on the question as to the involvement of the kidneys during the course of syphilis. However, I shall be pleased to give the subject attention in the future, and I trust it may bring out additional evidence of value.

In regard to Dr. Baker's remarks, I think he does not see the cases of inherited syphilis spoken of, because they die before they get to him. My experience is that young men with syphilis will marry. No matter if they have been warned of the danger and serious results liable to follow—still they will marry, and the first child almost invariably dies prematurely. The father may or may not be under syphilitic treatment, but the mother usually is at this time. The second child born, although alive, looks like one aged and infirm, with wrinkled skin and pinched face. He has a peculiar squawk instead of the natural cry of the healthy infant. Such babies always die. The next child, the third, is



born, and may appear fat and well developed. All goes well for a few weeks, when the nurse notices the natural discharges from the body irritate the skin, the buttocks become red, covered with blisters, and sometimes completely denuded. Such cases are frequently regarded as eczema. This is the child that probably comes to you, Dr. Baker.

With regard to Dr. Reich's question I may say that a few years ago we excised many chancres, hoping thereby to prevent syphilitic infection. It was taught by some that the poison traveled from the original lesion through the lymph channels, finally discharging itself into the blood, which process occupied days, weeks or even months, and that by extirpating the poison at an early period the infection might be averted. Such cases in my experience developed the usual feeling of malaise and subsequent constitutional syphilis. Cases are reported in which excision was performed within two or three days after infection, even before the lesion had obtained its characteristic features. We have here in Cleveland excised chancres at a very early date, but to our disappointment without the slightest effect in staying the progress of the infection. It is not done to any extent to-day. It likewise used to be the custom to touch the chancre with nitric acid or some other equally potent escharotic, but this as a routine practice has long since been abandoned. In the majority of cases in my own practice little or no attention is paid to the chancre, when phagedena occurs, however, local measures must be adopted. In regard to the treatment I would simply recall the remarks made in discussing the first case. Certain cases there are in which mercurial inunctions are valuable, again others in which intormuscular injections are well nigh imperative, while the majority of cases do best with the ordinary method of administration by the mouth.

In replying to Dr. Bunts, I have never observed a case of syphilis extending to the third or fourth generation, and doubt very much the possibility of such extension.

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## Notes and Comments.

**Dr. J. G. Spenzer** was confined to his house during the first two weeks of January, suffering with an infected eye contracted while handling a diphtheritic specimen.

**Dr. Myron Metzenbaum** is now House Surgeon at St. Alexis Hospital.

**Dr. C. E. Richards** is the new incumbent on the City Hospital staff.

**Dr. Frederick J. Schmoldt**, late House Surgeon at St. Alexis Hospital, is now located at 1737 Superior street.

**Dr. C. M. Hole**, House Surgeon at City Hospital until the 1st of January, is now located at 393 Cedar avenue.

**Dr. B. F. Hambleton** is the new addition to the house staff of the Cleveland General Hospital. His duties began on the 1st of January.

**Dr. Robert W. Williams**, late House Surgeon at the Cleveland General Hospital, whose term expired on the 1st of January, is visiting at home before beginning practice.

**Fractures.** In the class of fractures in which there is detachment of processes and apophyses, we very often fail to get crepitus, as in transverse fractures of the patella, fractures of the olecranon and coronoid processes of the ulna, and of the coracoid and acromion processes of the scapula.—*International Journal of Surgery.*

**Two Remedies**, one an old one with new indications, should receive the careful attention of medical men. Carbolic acid has always headed the list as the most certain and powerful of antiseptics. No living thing could withstand its dose of carbolic acid.

Its very destructiveness, however, placed it beyond the reach of usefulness and safety, even in the most skillful and careful hands. Carbolic acid poisoning by accident and by absorption and burns on the hands of surgeons and others who used the drug have been so frequent and destructive as to need no further comment. The discovery that alcohol is an absolute antidote to carbolic acid should mark the greatest advancement in antiseptic surgery. The pure drug may be applied to any surface and its action arrested at any stage by applying alcohol. If accidentally swallowed alcohol is its antidote. This knowledge it should be the business of every physician to make known to his patients.

In the treatment of suppurating wounds and old inflammations carbolic acid controlled by alcohol will be found of the highest value and positive cures wrought where the knife only offered hope of relief.—*W. J. Bell in Medical Herald.*

**Danger from Samples of Medicine.** The coroner of Philadelphia, after having investigated the death of a child from ingestion of sample pills, has called the attention of the director of public safety to the danger attending the indiscriminate and careless distribution of patent medicines and nostrums, particularly headache powders.—*Medical Record*.

**The Investigation of Beriberi.** According to the *Western Medical Review* for December 15th, Dr. Hamilton Wright, an alumnus of McGill University, and late registrar of the Royal Victoria Hospital, Montreal, has been commissioned by the British government to spend the next three years in the Straits Settlements investigating beriberi and other tropical diseases.—*New York Medical Journal*.

**Facial Spasm and its Relation to Errors of Refraction.** Stevens, in a report on facial spasm, says that the symptom picture differs but little in all forms, the spasm being usually confined to the distribution of the facial nerve. The etiology is often obscure, but may be from an infection of the nose or rhinopharynx or from cortical or subcortical disease. Ocular defect is more usually responsible. The refraction and muscle balance should be corrected and systematic after-treatment should be pursued.—*Medical Record*.

**Breathing.** Enough cannot be said of full, deep breathing (*The Chicago Clinic*). It is no hobby or wild notion, but if you would prove its benefits, practice it daily, and you will increase the circulation, purify the blood, and send it rich and hot to warm the feet, make ruby lips and plant roses on the cheeks. It will aid your digestion and give you a clean, sweet breath, promote sleep, quiet the nervous system, strengthen the throat and vocal organs and increase the chest capacity. It will also cure your asthma, catarrh and bronchitis and prevent lung trouble.

**The Pathology and Treatment of White Swelling of the Knee.** A. B. Judson asserts that white swelling of the knee goes from bad to worse so long as the patient continues to subject the joint to the weight of the body when standing, and the severe traumatism attending walking and running. He arrests motion by means of a posterior upright which is worn day and night. The weight-bearing function is held in abeyance by the use of the ischiatic crutch, worn only when the patient is up. In undue flexion of the knee the fixative brace may be used.—*Medical Record*.



**Appreciated.** The Medical Gazette Publishing Co., Cleveland, Jan. 6th, 1900. Gentlemen: The Cleveland Young Men's Christian Association wishes to express its appreciation of the value of THE CLEVELAND MEDICAL GAZETTE to our readers.

We wish to have your publication come to our reading room the coming year. May we ask you to kindly donate a copy for use in our reading room from Jan. 1st, 1900, to Jan. 1st, 1901?

Respectfully yours,

GEO. P. KURTZ.

**Thirst in Infants.** It is a mistake to suppose because milk is a liquid food it is at the same time a drink which is capable of satisfying the thirst of infants. Although milk appeases hunger, it makes thirst more intense after it has remained for some time in the stomach and digestion of it has begun. It is thirst which causes healthy, breast-nourished infants to cry for long periods of time in many instances. The child would be benefitted in a great many ways if allowed an occasional drink of water.—*Medical Classics.*

**Implantation of Both Ureters Into the Sigmoid Flexure.** Carl Beck (*Chicago Medical Recorder*, November, 1899) operated upon a boy with tuberculosis of the bladder. After curetting the bladder wall through a super-pubic opening and failing to get union of the wound or to make the boy comfortable on account of discharge of the urine and excoriation and eczema of the parts as a result of being constantly bathed in urine, both ureters were implanted high up in the sigmoid flexure, one on a line above the other.

The ureters were implanted in the bowel wall under a flap of peritoneum and muscle. The mucous membrane of the bowel was then perforated under the flap and the free end of the ureter was pushed through and allowed to hang free for one and one-half inches in the bowel lumen. The object of leaving the free extremities of the ureters in the bowel is to prevent infection and necrosis at the seat of implantation. According to Meydl's recent paper, in all cases which have not been operated according to this method, sooner or later symptoms of peritonitis or pyelonephritis develop. It is now five weeks since the operation. The course of convalescence has been uneventful. The patient can retain his urine for four hours at a time. By this method the bladder is entirely cut off and its walls can be removed in cases where it is involved in malignant troubles.—*The Chicago Clinic.*

**Constipation in Bottle-Fed Infants.** In constipated bottle-fed infants the fat should be increased to at least 4 per cent., regular habits taught, and a small quantity of orange-juice or stewed prunes administered daily. The suppository of soap or gluten or waxed paper inserted into the rectum at the same hour every day is very effective in promoting regularity of the bowels. Massage, both general and local, is often of the greatest service. Drugs should be avoided as much as possible. Codliver-oil and the sweet preparations of malt are often of value.—*Editorial in Pediatrics*, Nov. 15, '99.

**Insomnia.** One of the medicines which should be thought of is cannabis indica in treating insomnia. I always endeavor to cure insomnia with as little aid from drugs as possible, by means of physical exercise, regulation of diet, warm baths, avoidance of excitement, travel, and other hygienic measures. Nevertheless, we must often order medicine, and in some cases cannabis indica answers an excellent purpose. In senile insomnia with mental wandering, probably due to softening, nothing compares to the extract of cannabis indica given at bedtime, in a quarter to a third of a grain doses. The same remedy is valuable in the insomnia, restlessness and delirium of acute febrile diseases. It often succeeds in quieting the typhoid fever patient. This power was abundantly evidenced in the summer and autumn of 1898, when we had under our care at the Medico Chirurgical Hospital a large number of soldiers from the camps and field suffering from typhoid fever. I frequently obtained the happiest results from the tincture of cannabis indica.—*John V. Shoemaker, M. D., Philadelphia.*

**Headache and Eye Affections.** Dr. S. D. Risley (*Journal of the American Medical Association*) draws the following conclusions: (1) Abnormalities of the ocular apparatus are in a large group of patients the sole and sufficient cause of headache. (2) Abnormalities of vision may be the unsuspected cause, and therefore the absence of symptoms obviously referable to the eyes does not exclude them as an etiological factor in headache, insomnia, vertigo, petit chorea in children, and certain stomach derangements. (3) The recent or sudden development of symptoms, after attacks of severe illness, as typhoid fever, the exanthemata, etc., or in association with more or less acute exacerbations of some general dyscrasia, is not sufficient evidence against ocular participation in causing the symptoms. (4) The participation of

the eyes as an etiological factor in headache can be positively excluded only in the absence of ocular disease or after the most painstaking correction of any existing error of refraction or abnormality of binocular balance. (5) For the relief of reflex symptoms accurate corrections are essential, and these can be secured only by the more or less prolonged use of a strong cycloplegic. (6) Immediate relief by these corrections in a large group of patients is not to be expected, since the pain is frequently due to associated pathological conditions of the fundus oculi, and these require time for cure.

**Penetrating Wounds of the Eyeball.** Of the severer accidents which befall the eye, and which entail a great amount of responsibility upon the surgeon, into whose hands these cases fall, penetrating wounds of the eyeball are the most unfortunate. The question which arises at this time is not only what will be the result of the accident to the injured eye, but what influence will this injury have upon the fellow eye?

In answering these questions, all the circumstances entering into the case must be considered: 1. The kind of material which caused the penetration. 2. The location of the penetrating wound. 3. The tissues involved in the wound. And 4. Whether or not the foreign body penetrating the eye remained in the interior of the globe. Among the different materials which penetrate the coats of the eye, iron and steel, brass, wood, glass, and stone are the most frequent. In regard to the location of the injury, inasmuch as the cornea occupies the most exposed position of the globe, this tissue is the one most often implicated in wounds of this character, though the ciliary body and sclera often fall victims to penetrating wounds. The tissues involved in wounds of this character are the cornea, iris, ciliary body, lens, sclera, choroid, and retina, and in about the order of frequency above mentioned; but in degree of danger, the ciliary body and retina occupy the first place, but even these may be injured by some clean-cutting missile without the loss of the eye, provided, of course, this does not carry septic material with it. Nevertheless, of all the tissues of the eye to give the surgeon the most anxiety, when injured, the ciliary body stands first; hence the ciliary region has received the name of "the danger zone." The cornea may be penetrated by a sharp clean-cutting instrument, or flying missile without necessarily resulting seriously to the eye, provided the wound is clean, and often, even when the iris protrudes into the



wound, if treated in an aseptic manner, the wound heals, the protruding iris sloughs off, and the eye will remain in a tolerably safe condition. Should, however, the ciliary body be penetrated, and more especially by a rough or unclean object, it is to be expected that it will be followed by an iridocyclitis, which will not destroy the vision, but will result in a shrunken, useless eyeball. Nor is this all; for in a large number of these cases, a sympathetic ophthalmia will supervene, which is likely to render the uninjured eye practically useless also. However, the ciliary body has occasionally been injured, by a sharp, clean cutting object, and when sutured at once, has resulted in a quiet, though not especially useful eye.

The sclera may be punctured by a foreign body, which may enter the vitreous chamber, but if it does not carry infection into the globe, and the opening be closed within a reasonable time, the result is usually quite satisfactory to the patient. Should, however the foreign body carry infectious material into the vitreous body, it finds here a most desirable culture media, and at once a purulent ophthalmitis is set up, and the loss of the eye is assured.

Injuries to the choroid and retina occur by foreign bodies penetrating and remaining in the vitreous chamber, or by entering the eye through the sclera. When a body, however small, enters the vitreous chamber and remains there, it may remain for a number of months, or years, in an innocent manner, and in fact *may never* cause trouble, but an eye with a foreign body in it of whatever size, is never a desirable possession, for it not infrequently happens that, though the injured eye remains fairly quiet, it is impossible to state that it *may not* at any time cause sympathetic ophthalmia in the other eye, which usually results in blindness.

The question as to whether a foreign body remains in the eye after an injury of this character, is of considerable importance, and yet it not infrequently happens that it is impossible to determine this matter, though since the advent of the X-ray, it often happens that the foreign body can be definitely located, when before, this was impossible.

Foreign bodies may penetrate the cornea, and if small, lodge in the tissue of the iris. This may be removed through an incision, and if it has become imbedded in the tissue of the iris, an iridectomy will have to be performed which should include the foreign body; and if the eye does not become infected, and the lens is not injured, the eye may become nearly as useful as before.

Foreign bodies entering through the cornea may lodge in the lens, and if they do not infect the eye, and the iris is not injured to any great extent, the traumatic cataract thus formed may be extracted, and the eye be as useful as is usually the case after extraction of other forms of cataract. But if the foreign body enters the vitreous chamber, and as is usually the case, lodges in the retina and choroid, the danger to the eye is increased, as is also the difficulty of its removal.

If the injury be caused by a piece of steel or iron, it may often be successfully removed by the electro-magnet, of which at present there is a large variety, and the eye be saved, provided, as in all other cases, the eye does not become infected; but in these cases the injury done to the choroid and retina is often sufficient to destroy, to a great extent, the usefulness of the eye.

Other bodies than iron entering the vitreous chamber can seldom be removed, and these vary greatly in the resulting damage. Wood being of organic nature, is particularly liable to carry infection, and penetrating injuries caused by splinters of wood are especially prone to suppuration. Those caused by brass also, owing to poisonous compounds produced by chemical action of the tissues of the eye, usually cause a large amount of irritation, even though they enter the eye in a sterile condition. It might appear that foreign bodies in a sterile condition would never enter the eye, but as a matter of fact, this often does occur, but it is mostly owing to these pieces of stone, iron and other metals being broken off by a hammer, or other tool, becoming heated by the concussion to such a degree that they become sterile, and they do not convey infection.

In the treatment of penetrating wounds of the eyeball, the question of infection is an all-important one, for if this occurs, the eye is surely lost, and if there is good reason to believe that there is a foreign body in the eye that cannot be removed, the eye should be removed without delay. Again, when wounds penetrate the eye in the region of the ciliary body, whether infection occurs or not, the eye will become a useless organ, and will ever be a menace to the fellow eye, and enucleation should be performed at once. The few cases in which an eye with an injury of this character has been preserved, belong to the rare exceptions which only go to prove the rule.

I know of no sadder sight than some of these cases which come to the ophthalmic surgeon from time to time, where an in-

jury of the variety above referred to has been allowed to go without the proper surgical aid, and the injured eye was lost from the day of the injury, and within a few months, sympathetic ophthalmia has seized its fellow for a victim, and the unfortunate patient has been obliged to spend the remainder of his existence in darkness.—*Dr. William H. Dudley in the Lehigh Valley Medical Magazine.*

**Dr. Osler to Students.** While in Columbus recently Dr. Osler delivered a clinical lecture to the students of the Ohio Medical University. He closed his remarks as follows:

"Gentlemen, the most unhappy day of my life was when I sold my brains to the publishers. For a long time they had been after me to write a text-book, but I resisted. I never thought text-books so very much. I was tired of them and thought I was fitted for something better than writing a text-book, but finally I consented. I must have had neurasthenia or something else, and I beg your pardon for ever having consented to write a book. I have been sorry for students ever since, and trust when Osler goes out of vogue some one will have ready an easier text.

"I am very glad indeed to have met you all. I never meet a crowd of medical students but I think of Abernethy's remark, 'Good God! What will become of you all?' I know what will become of you. You will all do well. The medical profession is one in which every man can make a success, that is to say, he can be successful if he will work hard, study hard, and take an interest in his patients, not that they are patients, but because of his duty to mankind, will succeed. Practice not only with your head but with your heart also.

"Avoid professional jealousies and bitterness. Gad, doctors are worse than parsons in engendering ill feeling among themselves. When you locate, look up all the respectable doctors and leave your card. Tell them that you are going to locate and that you expect to deal squarely, and you will find they will treat you right. Shut up at once the patient who would tell you of the faults of a professional brother. They will go to another and say the same of you. If you go with the seamy side out, the same side will be turned toward you. Go with the woolly side out and all will be well and success crown your efforts."

**Surgical Hints.** In phlegmonous conditions affecting the hand or forearm, long continued baths in mild antiseptic solutions are of great usefulness. The ordinary elongated fish boiler is



very convenient for this purpose, as the whole arm and forearm may be placed in it and allowed to remain in it for hours at a time.

When searching for a pistol or rifle bullet, it is of the utmost importance to find out the exact position of the patient when he was shot, and the direction from which the missile came.

In making plaster-of-paris bandages, or in using those that are ready-made, see if the plaster appears damp. If so it will not set well, but may be greatly improved by placing it in the kitchen oven for a short time.

It is well to remember that in concussion of the brain death often takes place through paralysis of the respiratory centers. In these cases the prompt use of artificial respiration may tide the patient over his danger. If the heart centers appear to be involved we must stimulate, and for this purpose there is nothing better than heat applied to the præcordial region, together with such drugs as nitrate of amyl, nitro-glycerine, strychnine, ammonia, etc. Alcohol and strong coffee may be administered in enemata.

In partial amputations of the foot it is essential to prevent contraction of the tendo Achillis, either by tenotomy or by the use of splints, which will much interfere with the fitting of an artificial limb. The tendency of surgeons is more and more to discard these partial amputations and cut above the maleoli, an operation giving less chance of sepsis, a better stump for an artificial limb and greater ease of performance.

In children, a pain occurring symmetrically about both shoulders should lead the surgeon to examine for cervical caries. In rheumatism the pain is of a very different character, and practically does not affect both sides so evenly.

Make it a practice to always prepare packages of sterilized sponges, made out of cotton or cotton and gauze, and always containing the same number, say six. Then if you operate in a cavity you will always know whether you must account for six, twelve, eighteen, etc. We have seen an operator become pretty white when, at the end of an intra-abdominal operation, he declared he had forgotten to count his sponges before operating.—*Int. Jour. of Sur.*

**Topical Use of Quinine in Leucorrhœa.** Dr. Hardwicke speaks as follows about the topical application of quinine to the mucous membrane of the cervix uteri and vagina in cases of leucorrhœa: A patient, the mother of six children, who had been a

sufferer from the above complaint for some years, having used the various remedies usually prescribed in such cases, but with only temporary benefit, her trouble sooner or later recurring, adopted the use, from prudential motives, of what proved to be quinine pessaries. Since using them not only had her leucorrhœa disappeared, but her general health had improved. I have since used quinine topically in several cases of simple leucorrhœa, always with great success—in fact, I do not know of a single instance in which it has failed or in which quinism has been produced. It may be used in the form of douche or pessary. I adopt the latter form as being obviously the better one; the drug has a better chance of closer and more continuous contact with the congested membrane. I prescribe three grains of the hydrobromate in a one-half drachm pessary in combination with oleum theobromatis, but the pessus quininae of the "Extra Pharmacopœia," containing the hydrochloride, answers just as well. One insertion a day is generally sufficient.—*Canadian Pract. and Review.*

**Arsenic** has been experimentally tested by Mabilie as an *antidote to thyroidal intoxication* and found effective. It is well known that the various preparations of thyroid gland, when used as a remedy in fairly large doses, sometimes produce irregularity of pulse, exaggerated cardiac activity, and other disagreeable symptoms, which frequently compel physicians to dispense with it when otherwise obtaining excellent results. Mabilie claims that by the restraining action of arsenic these symptoms can be checked without in any way interfering with the ability of the thyroid to benefit the patient.

Before trying the arsenic clinically, Mabilie carried out a series of experiments upon dogs and rabbits, administering to them thyroid gland and Fowler's solution. He found that his theoretical views were supported by these experiments, and when he tried them clinically he found that he was enabled to use the thyroid gland in ascending doses more rapidly and with better effect when arsenic was given than without it.—*Merck's Archives.*

**The Natural Limitation of Syphilis.** Dr. J. D. Thomas (*International Medical Magazine*) says that syphilis, like all other eruptive diseases, has a clinical limit; and, again, like the other eruptive diseases, its sequela may be unlimited. Syphilis loses its contagious character in less than four years; its sequela may last as long as the patient lives. In cases thoroughly treated it may lose its contagious character in one year; this clinical fact we

know from occasional observation, wherein some of our patients, against advice, marry at this early period, but do not infect their wives, and hence have healthy children. The far limit of the contagion we know from observation; but its near limit in individual cases we are unable to settle. If any of the lower animals were susceptible to the disease we could, by experimental inoculation, tell each patient when the disease had lost its contagious character, and thus be enabled to state how soon the marriage relation might be entered upon.

And he adds: "When a woman, newly married, comes to me with syphilis, after marrying a man who had had syphilis three or four years before the wedding, I make bold to tell her that she did not acquire the disease from her husband, but from some fresher syphilitic."

In this connection the statement of Jonathan Hutchinson, quoted in our issue for October 7th, that "hereditary syphilis would disappear if the rule was generally adopted that two years' interval after infection should elapse before marriage," will be recalled.—*Monthly Retrospect*.

**When to Give Opium in Diarrhoea of Young Children.** It is contraindicated—1, in the first stage of acute diarrhoea, before the intestinal canal has been freed from decomposing matter; 2, where the passages are infrequent and of bad odor; 3, when there is a high temperature or cerebral symptoms are present; 4, when its use is followed by an elevation of temperature or the passages become more offensive. It is indicated—1, when the passages are frequent with pain; 2, when the passages are large and watery; 3, in dysenteric diarrhoea, together with castor oil or a saline; 4, in later stages with small frequent and nagging passages; 5, when the passages consist largely of undigested food, and the bowels act as soon as food is taken into them.—*Crandall (N. C.) Medical Journal*.

**The Operative Treatment of Uterine Fibroids.** F. A. Lockhart, M. B., C. M., Edin. (*The American Gynecological and Obstetrical Journal*), says: Operative treatment should be considered after medical treatment has been tried and failed, i. e., the growth becoming larger rather than decreasing in size. His special indications for operating are:

1. If the tumor is increasing in size and the woman is at or near the menopause.



2. If the tumor is impacted in the pelvis and the woman should become pregnant.

3. Excessive hemorrhage.

4. Degenerations of the tumor, as carcinomatous or suppurative.

5. When pressure or neurotic symptoms are prominent.

When a uterine fibroid is lying quiescent, causing no symptoms, he advises leaving it alone.

The nature of the operation depends upon the indications and the site of the tumor.

His operations are: (1) Curretting, (2) ligature of the uterine arteries, (3) oophorectomy, (4) myomectomy, (5) hysterectomy—(a) abdominal, vaginal, abdomino-vaginal, (b) supra-vaginal.

1. Curretting is simply a palliative measure; stops hemorrhage for a time and allows a diagnosis of the condition of endometrium.

2. Ligature of the uterine arteries. Dr. Lockhart believes this operation is simply palliative but he quotes Dr. Martin, who says this operation is indicated in cases of small interstitial fibroids, when they first appear near the menopause.

3. Oophorectomy should be limited to (1) cases where patient will not submit to removal of uterus; (2) where for any reason it is found impossible to proceed with the removal of the uterus after the abdomen has been opened, and (3) where celerity in operation is necessary on account of patient's condition.

4. Myomectomy should, he says, be limited to those cases of fibroid where the line of demarcation between the uterus and tumor is very decided, or else to those cases where one or more small nodules are projecting to some extent beneath the peritoneal covering the uterus, or whose presence has been discovered during an abdominal section for some other affection.

5. Hysterectomy. Total hysterectomy is the operation performed by most of the operators on this side of the Atlantic and on the continent of Europe. It is indicated (a) where the tumor is submucous and non-pedunculcated, and the cervix cannot be dilated sufficiently to allow of morcellement; (b) where the tumor is either interstitial, large and subserous, without a pedicle, soft fibrocystic, or undergoing degeneration; (c) where the tumor is complicated by diseased adnexa.

## Counter-Irritants.

### Coming and A-Going.

All the world's a stage, and all the numerous doctors merely ushers—both ways.—*The Doctor*.

### Just as Good.

"Dearest," asked the confiding girl, "am I really your first and only love?"

"No, darling," said the young druggist, "but you are something just as good."—*The Doctor*.

### The Fizzleologist.

*Visitor*: "Your son is in a drug store, I believe?"

*Old Lady*: "Yes, studying phizzleology."

*Visitor*: "I beg your pardon?"

*Old Lady*: "He runs the soda fountain."—*The Doctor*. . .

### Twisted Advertisements.

*Assistant*: "Why, Mr. Cook, what's the matter? You look worried."

*Mr. Cook*: "Great Scott, man! You have put the living skeleton museum cut in the baby food advertisement."—*The Doctor*.

### Infant Philosophy.

*Tottie* (aged five): "I wonder why babies is always born in the night time."

*Lottie* (aged seven, a little wiser): "Don't you know? It's cos they wants to make sure of findin' their mothers at home."—*Harlem Life*.

### Obedience.

A little girl who had been sent to school for the first time, on her return confessed to her mother that she did not like it a bit. "The teacher put me on a chair," she explained, "and told me to sit there for the present, and I sat and sat, but she never gave me any present."—*Exc*.

### A Question of Chemistry.

Said Mickey Finn to the patrons of O'Shaughnessy's bar-room: "Me by is stiddyng fwot he calls ke-mist-ree, but Oi think it's a dom humbug. He said last noit that if he tuk one bottle of oxy-gin an' two of hydero-gin, that thin he could make water. Oi said nothing, but Oi thought any dom fool knew that without going to a school to learn it."—*American Druggist*.

### Thunder and Lightning.

"So you have twins at your house, Johnnie?"

"Yes'm, two of 'em."

"What have you named them?"

"Thunder and Lightning, ma'am."

"What very singular names."

"Yes'm, that's what pa called 'em as soon as the doctor brought 'em."—*Exc.*

*Doctor:* "Your wife, sir, is suffering from general functional derangement."

*Mr. Parvenu:* "I know it. Maybe she'll give me credit with knowing a few things after awhile. I told her to quit gadding around to all these swell functions, or she'd be sick. Now she's deranged. Is she liable to be violent, doc?"—*Detroit Free Press.*

A hospital nurse reported that a patient "urinated by first intention" because he did not hesitate. Some applicants for insurance are not so fortunate.—*Medical Examiner.*

### Composition on Breathing.

A boy, 14 years old, who was told to write all he could about breathing in a composition, handed in the following:

"Breath is made of air. We breathe with our lungs, our lights, our liver and kidneys. If it wasn't for our breath we would die when we slept. Our breath keeps the life a-going through the nose when we are asleep. Boys that stay in a room all day should not breathe. They should wait until they get outdoors. Girls kill the breath with corsets that squeezes the diagram. Girls can't holler or run like boys because their diagram is squeezed too much. If I was a girl I had rather be a boy, so I can run and holler and have a great big diagram."—*Detroit Free Press.*

A country lad in the north of Scotland had his leg injured at the factory, and was treated for some time by the local doctor without markedly favorable result. His mother had great faith in a certain "bone-setter," and wanted her son to go to him but the boy objected, preferring, as he said, the "reg'lar faculty."

Finally, however, he yielded to his mother's persuasions, and was taken to the town where the famous bone-setter resided.

The leg was duly examined, and it was found necessary to pull it severely in order "to get the bone in," as the quack expressed it. The patient howled in agony, but at last the bone was "got in" and he was bidden to go home; in a few days he would be all right and could resume work.

"Did he na dae it weel?" said the joyous old lady as they started homeward.

"Ay, mither," said the lad. "He pullit it weel, but I was na sic a fule as to gie him the sair leg."—*Whitehall Review.*



# THE Cleveland Medical Gazette

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## Original Articles.

### ASEPTIC GANGRENE.

BY C. B. PARKER, M. D., CLEVELAND, OHIO.

The word gangrene suggests anything but aseptic processes. Memories of foul odors, prolonged suppurations, septic fever, and the like, arise in the mind as one reviews his professional experience.

Formerly, when the surgeon had occasion to produce a local gangrene by the actual cautery, his patient expected a long and tedious period of suppuration, during which the dead tissue was separating itself from the living. That this is not an essential part of the process of gangrene we have only to note how this same condition appears under aseptic precautions.

If the parts to be cauterized are rendered thoroughly aseptic and afterwards protected by a sufficient aseptic dressing healing takes place in the cauterized wounds without any suppuration, and complete healing follows in one quarter of the time. This most desirable result may be attained by suitable methods of treatment in nearly all the forms of gangrene.

Billroth classifies gangrene according to causation into five subdivisions:

(1) Tissues rendered completely incapable of life by mechanical, or chemical agencies.

(2) Obstruction to the flow of arterial blood and obstruction to the return flow of blood from a part.

(3) Gangrene—the result of disturbances in the nervous systems.

(4) Gangrene—the result of intoxicating substances in the form of germs, which either directly destroy the life of the tissue elements, or indirectly by their action on the vascular and nervous systems.

I wish to include within my remarks, the gangrene produced by the surgeon with the galvanic, or Paquelin's cauteries, as well as those occurring in open, contused and lacerated wounds; compound fractures, severe inflammations, and all injuries in which there is a probability of some portions of the injured tissue becoming dead.

These wounds in which a limited gangrene takes place are more important, as they are far more frequent than the cases of extensive death of a part. The danger to the life of the patient is just as real; while the indications for treatment and the process of absorption and repair are identical.

"The phenomena of the process of gangrene or death in a part," Sir James Paget remarks, "are most complex. It is not a simple ceasing to live of certain tissues. It involves the vital question of cellular activity—of nutrition itself."

Gangrene—like inflammation of which it is the sequence—is a local disturbance of the normal nutrition. A disturbance in the direction of acceleration and death of tissue.

It is a well-recognized physiological principle, that in normal nutrition effete or dead materials in minute particles are constantly being separated from the body through the excretions, and that certain other portions of the waste materials are being re-elaborated by the blood purifying organs, and restored to the circulation to serve further purposes in the process of constructive metabolism.

This, the physiological process, is exactly counterfeited in gangrene. When a part is no longer capable of living, a physiological process, only excessively exaggerated, is at once set up. On the one hand, of separation or excretion of visible instead of molecular particles of dead tissue from its contact with the living; and on the other, absorption into and after re-elaboration, of restoration to the body of such materials as can be used in the processes of nutrition.

An illustration of these two processes is afforded by the casting off of the crown, and absorption of the fang of the temporary tooth in the development of permanent teeth; or, as the catgut within the tissues is absorbed, and the free cut ends are thrown off after ligation of a vessel. Thus it happens with a tissue that be-

comes gangrenous. A part is thrown off, and a part is absorbed. The new granulations formed on the border between the living and the dead parts penetrate the dying tissues, the cells devouring, while the capillaries absorb away the fluids. The extent and activity of these processes depends among other causes upon the extent and location of the injury, the vascular and venous supply; condition of health at time process is inaugurated.

Wherever any portion of dead tissue is exposed to the air there immediately fermentation or putrefaction begins. This process is due to the presence and activities of living germs. Their activity is favored by the temperature and moisture of the part. These germs are inimical both in their presence and the products of their activity, to living tissues. An immediate warfare is waged between the living tissues and the germs and their products; suppuration occurs, fever is present.

This struggle necessarily lessens the power of resistance in the injured tissues as well as their powers of absorption, and thus of the amount of material saved to the body.

On the other hand, the germs or their products entering the body spread in the tissues, causing a rapid and distinct extension of the process of mortification. Traumatic gangrene, hospital gangrene, noma, and cancrum oris, are examples of various forms of gangrene due to specific germs.

The granulations springing up along the line of separation between the living and dead tissues furnish the best protection against the entrance of the germs or their products. How often a wound is examined which has had the most foul discharges in contact with it, without producing any effect upon the health!

This immunity is not due, as formerly supposed, to the absence of sympathies in the granulations, and this absence of the power of absorption, for Maas has demonstrated that granula-tissue will readily absorb all kinds of fluids. Billroth says we can only affirm that living granulations have the power of withstanding germs and their products, and that when absorption does take place the granulation surfaces have been wounded in some mechanical or chemical manner. This property in granulation tissue is similar to the restraining power of living blood vessels upon the fibrin ferment and fibrin factors present in the blood.

The objects then in the treatment of gangrene, or where from the character of the injury it is suspected it may occur, are clearly twofold:

- (1) To prevent the entrance of the germs or their product.



(2) To destroy and remove them when present.

In the first instance an aseptic gangrene can be secured in all operative cauterizations by first rendering parts aseptic, and afterwards protecting the cauterized parts by an ample aseptic dressing. This dressing should be ample so as to quickly and completely absorb the secretions, always considerable, and which furnish such a favorable nidus for the lodgment and development of the various germs.

In the second method of treatment, it is not alone necessary to prevent the introduction of germs, but we must before all, remove or destroy those germs introduced at the time of injury, either through the air, or carried in by foreign bodies of various kinds, or from the unclean dressings applied at the time of injury. To accomplish this the injured parts must be thoroughly cleansed by scrubbing with soap and water and a hand brush. If the pain is too great a general anæsthetic can be given. It is often better to give the anæsthetic to render the parts thoroughly aseptic than to give it for the removal of any part.

All stitches should be avoided, as too intimate coaptation of the wound prevents free drainage and in all these cases under consideration the vitality of the tissues are so impaired that union by first intention will not occur.

A moist bichloride dressing not stronger than 1-4000 and covered by protective is applied next to wound. Poultices of whatever kind are never to be used, for the reason they can never be rendered aseptic.

We may dispose at once of the vexed question of heat and cold in this class of cases. A certain temperature is necessary to all vital processes, therefore warmth, and usually dry warmth, from hot water bottles, is the best form of applying it.

Two most important mechanical adjuvants to successful treatment, are pressure and position with rest. Pressure by bandaging over thick layers of salicylic, borated or carbolated cotton, and by means of splints with continuous elevation of the injured parts.

By these methods of treatment carefully carried out, any recent gangrene can be rendered aseptic, and the terrors of the process of gangrene prevented, and the integrity of important members and structures of the body preserved, which must otherwise be lost by the destructive agencies of septic germs and their products.

## MEDICAL SUPERVISION OF SCHOOL HYGIENE.

BY L. K. BAKER, M. D., CLEVELAND, O.

*Written for the Cleveland Medical Gazette.*

At the International Convention of the American Association for the Advancement of Physical Education the question of medical supervision of school hygiene was discussed at length.

It seems that the supervision of physical exercises in several cities has fallen into the hands of non-medical women. Very naturally they desire to magnify the importance of their positions by making the supervision of other phases of school hygiene a portion of their duties. This increase of work would increase the number of their assistants, thus adding to the importance of their positions. In order to bring this to pass one of the most able of these women advocates the division of the supervision of the subject, giving several phases to the physical educationists and the rest to various other parties.

It is pertinent to note in this connection that most of the groundwork upon which our present knowledge of school hygiene rests is the result of the labors of European medical men. That some of the leading authorities in this country are medical men and that the control of most of the positions of influence in physical education is now in the hands of medical men. Many of the lay physical directors who are drawing salaries are slighting their work while pushing for a degree in some medical college in order that they may increase their ability as teachers and directors, and ultimately command larger and better paid positions. This of itself is a clear indication of the drift of opinion among physical directors. It may also be said that the affairs of the American Association for the Advancement of Physical Education are controlled almost entirely by medical men and that in so far as they expressed an opinion it was unanimously in favor of medical supervision. They took the ground that neither graduates of normal schools of gymnastics or schools of pedagogy or of medical colleges can, as such, be classed as experts in school hygiene. That, however, the graduate of a medical college has the best foundation upon which to begin the building of such a specialty. While it was admitted on all hands that the ordinary practitioner and the specialist in other fields of medical endeavor do not possess the special knowledge necessary to expert supervision of school hygiene it was conclusively shown that the exhaustive study prescribed for the physician by present medical

college courses in the fundamental branches—*anatomy, physiology, hygiene, pathology and therapeutics*—places him in a position where he may easily outstrip the graduate of a two years' normal course, in the acquisition of the special knowledge and practice necessary to expert work in the supervision of school hygiene.

The practical training of the physician leads him to apply the principles of his profession to facts as he actually finds them in individual cases. On the other hand quite a minority of teachers observe, and teach, "in concert," oblivious of the mental or physical condition of the individual pupil. And not a few teachers who stimulate to unusual activity the minds of their pupils are quite obtuse as to the physical conditions surrounding their children. To illustrate: A well-meaning and really good teacher, of several years experience, was dumbfounded when, at the close of last school year, it was shown her that thirty of her fifty pupils had not been able to touch the floor with their feet when sitting in an erect position. The frequent repetition of similar instances quickly convinces the practical mind of the physician that the fundamental training of teachers in school hygiene is not of such a character as to enable them to detect easily and quickly those physical conditions in the school room or in the child which may impede his progress in school or interfere with his health. This suggests more instruction in hygiene in normal courses. Instruction of such a character, given by such authority and backed by such requirements that it will be taken in earnest by the normal school pupils and incorporated in that part of their training which they feel they must use daily. For their pupils this would mean good care of health while in school and practical teaching in physiology and hygiene instead of an attempt which most doctors agree is farcial.

Not a few teachers teach by tradition. And when good reasons for the introduction of improvements are offered they are always ready to exclaim *yea! yea!* But the minute the back is turned they go on in the old rut and do it not. This professional hypocrisy is difficult to contend with. It requires close and sometimes severe supervision to keep such people within sight of the line of progress of the teaching force. Especially as they are often people of character, ability and force, but of unchangeable habits. They are found, not only in the rank and file but in principalships, on school boards and in the chairs of superintendents. Fortunately for the better teaching of the old subjects and for the



interests of the newer ones, public sentiment is rapidly superannuating this class of teachers. Having lost a position they find it extremely difficult to secure another. To such teachers we may add another large class who grumble continually when anything new is added to their work, or when its form is in any way changed from the traditional. These cry down all improvements on the plea of being already overworked.

Now with the physician it is a professional necessity to observe closely the individual and his surroundings and then act in such a manner as to conserve to health. And if the doctor can secure the same habit of thought for the teacher in all matters pertaining to the physical welfare of the little people who are so much of the time at her mercy he will not only confer a great benefit upon the children, but will add greatly to the stability of the profession of teaching. Not only so, but the improvement of the teacher in sanitary knowledge followed by the improvements of her invironments, will change for the better her rather low health average, thus adding to her happiness in her work and to her chances\*for success.

Hence it is important that members of the profession use their influence with teachers of their acquaintance and with school officials for constant improvement in school sanitation. In view of the position taken by some physical trainers, as well as by some other teachers, physicians should stand together in insisting that the influence of the profession, through properly qualified members, be brought to bear upon all phases of school life which affect the physical welfare of school children. That the force of this influence be not weakened or dissipated by relegating certain phases to less competent classes of individuals. That more means be placed at the disposal of medical supervisors for the successful prosecution of their work and that more attention be given by school officials to their suggestions.

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## THE DISINFECTION OF SCHOOL ROOMS AND PUBLIC CONVEYANCES AFTER EXPOSURE TO INFECTIOUS DISEASES.\*

BY FRANK WARNER, M. D., MEMBER OHIO STATE BOARD OF HEALTH,  
COLUMBUS, OHIO.

It has seemed to me that the dissemination of infectious diseases through neglected school rooms and public conveyances

\*Read before Conference of Ohio State and Local Boards of Health, at Columbus, Ohio, January 6th, 1900.

after exposure to this class of cases is of probably sufficient frequency to claim, for a few minutes, our attention.

Often, as a physician, I learn of children leaving the school room sick of, what a few hours afterwards is pronounced by the physician who is called, diphtheria or scarlet fever, and I regret to say that it has frequently occurred over our state of late that some cases of seeming chicken pox but in reality smallpox, have come away from the school with the disease unrecognized. This has not always been the fault of the physician by any means; for many parents are content to look after so simple a matter as chicken pox themselves. No fault could be found with this if the chicken pox were always chicken pox. But it is not, as has been proved time and again in different sections of the state. In passing, it is evident there must be some real difficulties in the discrimination of these two diseases, especially in the peculiar form of the recent epidemic of smallpox. It has shown itself in an extremely mild form. Yet, not unlike that in at least one preceding epidemic. Of course, as you are well aware, some physicians have unwillingly yielded to such a diagnosis, in some communities, holding for a time at least to the notion of chicken pox. This is not the time nor place, following the subject of my paper, to attempt to discuss points of differentiation in the diagnosis between these two diseases. But, if there are some real difficulties presenting themselves in this discrimination, I then should wish to include chicken pox in the class of infectious diseases which should call for the disinfection of the school which they had just left. Not during all seasons, but certainly when smallpox of the grade we have recently encountered is in existence.

There is no question that in the present well understood matter of the prevention of the spread of smallpox, a school room would be disinfected if it were learned that an infected pupil had recently been present. But it is equally true of patients transported in public conveyances. Is there not a necessity of disinfecting public vehicles after carrying not only patients suffering from smallpox, but to a lesser degree those who are suffering from diphtheria, scarlet fever or measles?

Then, if there is a necessity of disinfecting vehicles after carrying patients suffering from contagious diseases, it seems to me a considerable good could be done in their prevention by disinfection of vehicles used in the transportation of the dead who have died of contagious diseases. A hearse which has been used to transport a corpse which has died of any contagious disease,

should be disinfected immediately after such transportation. Any express wagon used, as I understand they are occasionally used, to transport especially those who have died of smallpox, should be treated in the same way.

Such vehicles are a menace to those who come near them for a greater or less length of time. Proper disinfection would immediately remove this danger, whether the danger be great or small. At least, it is only attention to small details and the removal of small dangers that anything has been accomplished in the prevention of contagious diseases.

While disinfection has been undertaken in a few school rooms in the state after the report of a contagious disease having been in that room, I believe it should become a general custom.

Right along this line, greater care should be given to the cleanliness of the school at all times. Whatever dirt chances to be present serves as a nidus to hold infectious germs and give them an opportunity to develop. Disinfection is accomplished with much less ease and still more uncertainty in the presence of dirt which may contain the germs.

Then again, we should remember, light, ample light at all times, is the eternal enemy of pathogenic germs. Just what prompts some janitors to draw the shades of the school room, placing it in absolute darkness on every conceivable occasion, is more than I can understand. It is certainly a pernicious practice that should be abolished.

The dilution of the vitiated atmosphere of the room by ample fresh air is of great value at any time, but especially valuable at a time when contagious germs are present, brought in by some child whose clothing had become impregnated perhaps by an unknown exposure to a contagious disease. Dilution of the germs by fresh air has the same effect upon them that the liberal dilution by the fresh water of Lake Michigan will have upon the sewage of Chicago in their new drainage canal, where it will receive from three hundred thousand to six hundred thousand cubic feet of fresh water from the lake every minute. The thorough airing out, or in other words, the liberal dilution of an infected atmosphere in a confined space with fresh air serves as a strong aid to our disinfection. As the infectious air in the room is diluted with fresh air it not only allows a diminished number of contagious bacteria to bear upon the child but also resupplies something like a normal quantity of oxygen.



Scientists contend that with one per cent of oxygen removed from a room, a burning candle losses 5 per cent of its brilliancy. Is it unreasonable to suppose that children breathing this air would suffer in their inability to resist the inroads of contagious germs? What disinfectant should be used? Nothing, so far as we now know of, excels formaldehyde gas. It is reasonably certain in its action, and with slight expense. It has now been demonstrated by a large number of observers that formaldehyde gas is perfectly harmless to the finest fabrics. Varnished articles do not suffer in the least. Neither do silver nor plated ware show any ill effects. The only line of fabrics that lose their color when subjected to this gas were those that very readily faded when exposed to the sun. So that, practically there is no objection to its use.

To make the gas effective it must be generated quickly. Dr. Wyeth Johnson, Bacteriologist to the Provincial Board of Health of Montreal, insisted on this point in his report on Disinfectants at a recent meeting of the American Public Health Association at Minneapolis, to which I had the pleasure of listening. The more quickly you can fill the space which you wish to disinfect the greater number of germs you will have destroyed. If you require only one hour to generate the intended amount of formaldehyde gas to fill the space, it will be found far more effective than if you consume two hours in the generation of the same amount of gas. This is very easily understood if you come to reflect that some of the gas escapes from the crevices of the doors and windows, despite the fact that you may seal them by pasting paper around the crevices. It is important to bring the whole of the gas to bear upon the infected sphere as nearly as possible at one time, rather than to present the same amount in divided quantities. Any apparatus which fails to meet this essential condition is one to be avoided.

It is not the best time to attempt a disinfection by this gas during a high wind. The escape of the gas from the crevices of a room of course are greatly augmented at this time. Yet, by extra precaution to prevent as much escape as possible, and by generating a little larger quantity than you would otherwise, the results will be quite satisfactory.

The temperature of the room exercises an influence over the effectiveness of the disinfecting power of the gas. It does better work in a warm room than in a cold one.

The Chicago Board of Health has dispensed entirely with a generator. They simply spray formaldehyde onto sheets suspended in the room. In talking with their Bacteriologist, Dr. Adolph Gehrman, recently at Minneapolis, he informed me that what they insisted upon was to get the spray evenly distributed over the sheet and not allow drops of any size to form anywhere, as this destroyed completely the effectiveness of its work. This plan has not been generally adopted, and it does not seem that a sufficient number of observers have reported upon this method to yet accept it as equaling the disinfecting power of the gas generated in the usual way. However, when no generator is at hand, and the necessity of the disinfection has arisen, this method should be employed, and you will at least have the authority of the Chicago Board of Health for its effectiveness. But until more observers approve this plan, it seems to me we should hold to some well approved generator.

Dr. W. K. Jacques, of Chicago, presented to the Section on State Medicine, at the meeting of the American Medical Association held in this city in June, 1899, a method of impregnating a room with formaldehyde gas by pouring formalin in hot water. He suggests keeping the water just below the boiling point, for the reason he states formaldehyde gas is given off in abundance at this point, but the innocuous paraform if the water is kept at the boiling point. This is not a method which has received the sanction of observers, however. He even goes so far as to suggest this method in the sick-room, in the presence of the patient, generating the gas slowly. But any quantity of gas that a patient would readily stand, I am sure would prove entirely ineffective. The slow production of the gas is the very thing the best observers and those who had been appointed to make these observations by the American Public Health Association, insisted gave the poorest results. That the rapid production was what should be attained. No objections were heard to this latter proposition at the recent Minneapolis meeting of the Association mentioned.

One objection always arises where there is only a small amount of disinfection needed. That is the expense entailed in securing a suitable generator to do the work. To meet this very objection, Dr. Robinson, of Maine, reported to the recent meeting of the American Public Health Association at Minneapolis, a method for the production of formaldehyde gas, that he assured the Association met every requirement. He simply makes a small box of sheet iron, perforating the sides and top, rolls up some

heavy asbestos paper that will just fill the box. Then solders on the top. When he wants to disinfect a room he pours in a proper amount of the solution of formaldehyde, saturating the asbestos paper. Then he places the box over some source of heat and generates the gas. Not having experimented with this method, I cannot vouch for it, but from the well known reputation of the gentleman who makes the suggestion, I feel it is worthy of a trial at least.

There is little doubt that the large proportion of the innocuous infectious germs settle down with the dust of the room onto the floor and window ledges. The washing of them with a two per cent solution of formaldehyde will come next in importance to the more general disinfection with the gas. Indeed where the infection of a room is decided and of prolonged duration, there is an immense advantage in washing the floor and window ledges with the formaldehyde solution of the strength mentioned, in addition to the fumigation. For the germs may have found lodgment in crevices and become protected with surrounding layers of dirt in a way that prevents the gas destroying them.

Finally, if one has not at hand the best means of making a disinfection, it is much better to make some reasonable attempt than to let it go by default. Then, as opportunity presents, secure a generator that will develop a large quantity of gas in a short space of time, that the whole of the gas may act at one time upon the bacteriæ of an infectious character.

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## REPORT OF CASE OF SEPTICAEMIA FOLLOWED BY PYAEMIA.

BY O. B. CAMPBELL, M. D., CLEVELAND, OHIO.

February 24, 1899. Was called to see Mrs. M—, aged 28, married, pregnant three months. Had had one child and several miscarriages. Diagnosis—"Grippe" with the usual characteristic symptoms. Feb. 26—miscarried. I was not present to deliver, but a nurse took care of the foetal mass which I saw. It seemed to be entire. So nothing was advised as special treatment aside from rest and quiet in bed, with the ordinary remedies for the "Grippy" condition. There was nothing special to record for two weeks. The patient seemed to be progressing rapidly toward recovery from both troubles, so far as to be able to be up, and let her nurse go. On the 14th or 15th day after the delivery she was



taken with a chill followed by high temperature—104 deg. to 106 deg. Pulse became very rapid at times.

Omitting the details of a plain case of septicaemia, for you are all familiar with its vexing and dangerous symptoms, the day of the first chill, fourteenth day after delivery, I used a dull curette and the results were negative. The uterus was irrigated thoroughly with a bi-chloride solution. There did not seem to be any improvement from any treatment, but on the contrary the patient seemed to grow worse, having recurring chills, profuse perspiration and fluctuating temperature.

March 22nd, twenty-five days after the miscarriage. Dr. P. H. Sawyer saw her with me and concurred with me that there was a septic condition caused probably by some absorption of putrid matter from the uterus, and advised a thorough curetting. I did not feel like taking the responsibility of making fresh absorbing surfaces with an already poisoned blood. Dr. Humiston was called and after examining the patient agreed with me that further local interference was not needed and could do no good.

She was treated on general principles, with some improvement as to the chills and sweats, but there was an increasing localized pain and tenderness over the right lobe of the liver, which seemed very much enlarged. The pains heretofore had been erratic and shifting. I then concluded that the case had passed from septicaemia to a pyaemia or was one of septo-pyaemia, that there was not only pus in the blood, but local abscesses were forming, probably in the liver, that there might be emboli ready to lodge most anywhere. March 29—four weeks after miscarriage, I called Dr. Allen to see the patient with me with a view of surgical relief. I believe he had no doubt, at the time, that there was an abscess or abscesses in the liver, but did not advise operating. It seemed to him, as well as to myself, that there was no relief for her, and that she would die, as most of these cases do after a lingering illness.

One week more and evident signs of emboli floating in the circulation developed. The left leg became swollen, very tense; after that the right.

Another week swelling all gone and all the symptoms improved, and by May 31st, a little more than three months after the miscarriage, temperature normal throughout the day, and all the severe and bad symptoms gradually disappearing. Conval-

escence with general improvement and blood making processes begun and continued up to June 17th, when I dismissed her practically well.

October 15th, four months later, I was called to see her again. She had had a slight chill and was suffering from pain in right side in the region of the liver. Temperature 103 degrees, a slight cough and some shortness of breath. Pulse 140 and small. I saw her twice a day for four or five days, and after a careful study of the case came to the conclusion that the abscess was still there that I thought was there five months before and, probably by ulceration, leaking pus into unprotected tissue. I so told my patient's husband and we were waiting and talking again of the advisability of surgical interference. The days went by and again she began to improve. I could get no fluctuation (the patient being very fleshy) and so thought best that while my patient was better to let her alone. She rested pretty well then, ate well, not much temperature, but quite a rapid pulse.

November 3rd, 4th and 5th she was so much better, she sat up and seemed to enjoy everything. On the night of November 6th—about three weeks after the last attack, I was called at midnight. Found her suffering from severe dyspnoea and cough, heart bad, severe perspiration, cold. A hypodermic of morphine and strychnia quieted her and relieved the distressing symptoms somewhat for the time. I concluded to remain in the house, instructed the nurse of the seriousness of the symptoms and to call me if she saw any change, which she did about four o'clock. The heart was about to give up. The patient remarked to me "She was so tired," and died immediately.

*Postmortem.*—I held a postmortem about 10 o'clock a. m., Dr. Ryley and Dr. Bryant present. We found an abscess holding a pint and a half of pus external to the right lobe of liver, adhesions, so that the large part of the wall was the diaphragm. Liver very much enlarged. Ulcerations, two small openings through the diaphragm leaking pus into lower part of right lung; all of right lung congested, some fluid in right pleural sack, not dark; uterus normal and healthy; right ovary congested and somewhat enlarged; (might have been infected in the beginning); heart normal in size and apparently healthy. These thrombi I show you, were one loose, an embolus lodged in the aortic artery caught in the valves, which no doubt caused the sudden death; one in the pulmonary artery near the heart, quite fast. The third

I believe was part in one of the pulmonary veins and part in the heart auricle.

I report this case and show these specimens because I think they are out of the ordinary and therefore of interest.

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### SCOPOLAMINE AS A MYDRIATIC.

A rapid and efficient mydriatic for diagnostic purposes will be found in scopolamine, an alkaloid obtained from *scopolia atropoides* and also (according to Spenzer) forming a large per cent of commercial hyoscyne. One to two drops of a quarter of one per cent solution will produce mydriasis in 5-7 minutes. In some patients the pupil will return to the normal in 24 hours while 2-3 days may be required before all effects have passed off.

Such a ready mydriatic places within the convenient reach of every practitioner, in office or at the home, an aid to more perfect diagnosis. It has proved of especial value to the writer recently in one case of retinitis syphilitica and another of retinitis albuminuria.

F. C. H.

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## **Abstracts and Extracts.**

### LATENT CANCER OF THE STOMACH.

WM. OSLER, M. D., AND THOS. M'CRAE, M. B., PHILADELPHIA MEDICAL JOURNAL FEB. 3, 1900.

In a study of 150 cases of carcinoma those unsuspected during life are found most commonly in old persons, with no symptoms, very slight ones, or those regarded as indicating ordinary dyspepsia. Three groups are described.

1. Those cases showing gradual enfeeblement without special indications.
2. Cases, with absence of gastric symptoms but with associated lesions which seem causative of the condition.

Two cases of nephritis with albuminuria, granular and hyaline casts, edema, rapid emaciation but no signs of cancer, showed at an autopsy carcinoma gastrici. One case of phthisis, pulmonalis with pneumothorax showed no gastric signs, but at an autopsy a large fungoid cancer with secondary growths in glands and liver was discovered. Case of multiple thrombosis of superficial veins, sterile thrombi, marked anaemia without gastric symp-



toms showed gastric cancer with extreme glandular and hepatic involvement.

3. Cases in which metastases completely mark primary lesion. Case with signs of ataxia developed tumor in right iliac fossa, no gastric signs but autopsy showed primary colloid carcinoma gastrici.

Case regarded as primary neoplasm of thorax with metastases on ribs proved to be primary cancer of stomach.

Case with first symptoms a marked ascites, simulating hepatic cirrhosis, except for bloody ascitic fluid, diagnosed by exploratory operation as colloid cancer gastrici. The possible remarkable extension of cancer without signs is noted.

F. C. H.

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### CARBOLIC ACID POISONING.

In a case of poisoning from carbolic acid, after washing out the stomach, strychnia, whiskey, coffee and warmth seemed of little avail and the patient had increasing coldness of feet and nose and no radial pulse, atropine hypodermically to 1-25 gr. in successive doses of hundredths was followed by rapid improvement and final recovery. The urine presented a marked smoky appearance for 24 hours later, with a few red blood cells but no albumin.

F. C. H.

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### THE MOST IMPORTANT POINT TO BE CONSIDERED IN THE TREATMENT OF APPENDICITIS.

In an article in the *Hot Springs Medical Journal* Dr. A. J. Oschner says that the observation of this one point in the treatment of this disease will do more toward saving the lives of these patients than any other thing. He calls attention to the natural elimination of the appendix in this disease; its peculiar anatomical location making it possible for the omentum and the small intestines to apply themselves in such a manner as to practically isolate it from the general peritoneal cavity. Provided nothing disturbs this arrangement, and the patient suffer from catarrhal appendicitis, the condition subsides in a short time and the patient recovers. If the patient suffers from perforation or gangrenous appendicitis the affected portion is surrounded in the same way and a comparatively harmless circumscribed abscess is formed. In case the small intestines or omentum are drawn

away from the affected area the infectious material is distributed throughout the peritoneal cavity and the patient succumbs to diffuse infectious peritonitis. Now, the point is this: Don't feed your patient by way of the stomach. The introduction of milk or any other food into the stomach sets up peristaltic action of the stomach and small intestine and the intestine is drawn away from the very area it ought to protect. Moreover, the intestine becomes filled with gas which is forced through the ileocecal valve and further disturbs the conditions to be desired. The patient must be fed by the rectum. Nothing but water, preferably hot and in small quantities, is given by the mouth. This method of treatment disposes of two sources of pain—pressure from gas and friction of inflamed intestinal surfaces from peristalsis. There are two conditions under which this plan fails. (1) In very emaciated patients, the omentum may be too small to cover the appendix. In such cases immediate operation is indicated. (2) In patients where the attack commences after a large and indigestible meal. Gastric lavage to remove remains of the meal and gas should be done in these cases. The doctor concludes his article as follows:

"My experience has taught me that it is best to continue the exclusive rectal feeding for at least four days after the patient is apparently well, and never to give a cathartic of any kind unless I see them within a few hours after the beginning of the attack, in which case I usually give two ounces of castor oil in beer or malt.

"After the first day the cathartic may give rise to the same disturbance as feeding by mouth, and it may be followed by the same deplorable results."

CLARK.

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### THE DOCTOR'S PAY.

Another aspect to this subject is the direct loss to the doctor by bad debt, slow pay, etc. No class of men, professional, mechanic, merchant or farmer, loses so great a proportion of his earnings. The practically compulsory credit system has done us incalculable injury. A man that can't get credit for ten pounds of sugar or ten yards of calico thinks nothing of standing his doctor off for a ten-dollar consultation for which the doctor has probably only charged him one dollar. He would be grievously offended if asked for spot cash. People tell it as a joke that the doctor's bill is the last one settled. They even tell the doctor himself that if they have anything left after paying the milliner,

the florist, the jeweler, the confectioner, and all the other luxury dealers, that they will pay him off, with never a thought of the jar that it gives his nerves. Who is to blame?

Another idol that should be broken is the custom of rendering bills yearly or half yearly. The custom has made the doctor not only poor, but a poor business man. To affirm that prompt presentation of bills compromises the dignity of the profession is silly and absurd. What is the custom of our step-brother, the lawyer? He compromises his dignity and your bank account by collecting your money, pocketing his fee—simply to save you the trouble of writing a check—and sometimes he hands you the little balance. Verily, every young man ought to have a business education before beginning the study of medicine.

Misconception of the standing of the profession and the value of medical service has arisen through the doctor's own fault, from the unprofessional value he has placed on his service, and from the unprofessional method he has adopted of fixing the value of that service. Is it not a fact that most people estimate the value of medical service by the number of visits made, the length of time engaged, the number of miles traveled, or the amount of medicine prescribed, paying little or no heed to skill? And is it not a fact that doctors have accepted this way of estimating the value of their services; and is not the absurdity of it glaringly apparent? Upon skill, and skill alone, should rest the way to make a charge for professional service. A large part of the public look upon doctors as skilled mechanics; the only difference they see is in the doctor's dress and ordinary mode of locomotion. They think because he rides in a buggy, therefore he ought to charge less for his work.—*John G. Cecil, B. S., M. D., on "The Doctor's Pay" in the American Practitioner and News.*

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## THE TREATMENT OF ACUTE GENERAL PERITONITIS

In the medical treatment of acute peritonitis, food by the stomach should be entirely suspended from the first. Bacteria assail the peritoneum not through normal, traumatic or pathological apertures only—through the tubes and perforative wounds and ulcers—but also through the structurally intact bowel wall. In cases of acute appendicitis, with neither gangrene nor perforation, colon bacilli and other bacteria are found on the peritoneal surface of the appendix. Under similar conditions, bacteria may traverse the living walls of the bowel and thus excite a local or



even general peritonitis. In peritonitis always, and in its causative conditions generally, impaired digestion exists and predisposes to fermentation and putrefaction of the ingesta; gas develops and distends the intestines, impeding the local and general circulation; bacteria multiply enormously, invade the intestinal mucosa and muscularis and finally the peritoneum itself; the muscularis succumbs to distension, imperfect circulation and nutrition and at last, infection; functional obstruction and intense sapremia set in and the patient is lost.

Except in occasional cases of fatal shock, acute peritonitis kills always by toxemia—never by inanition—and of this toxemia the ptomains of gastro-intestinal putrefaction not infrequently furnish the fatal increment. I wish to emphasize by repetition my belief that the condition of the alimentary canal often determines the outcome of acute peritonitis. Rectal feeding should take the place of stomach feeding but not until after 24 to 36 hours of absolute fasting.

Alimentation by the rectum, supplemented in extreme cases by the subcutaneous tissue, to the entire exclusion of the stomach, solves the question of nutrition in these cases as best it may be solved. A full meal by the rectum may consist of two eggs, one-half pint of warm milk, two tablespoonfuls of milk, sugar and four ounces of warm water, well mixed with the contents of one peptonizing tube (Fairchilds) and fifteen grains of powdered naphthalin. **In prolonged rectal feeding, an antiseptic is indispensable.** Without it, the nutrient enemata swarm with micro-organisms and, carried as they sometimes are by reverse peristalsis into the small intestine or occasionally even into the stomach, may produce the very troubles which this method aims to prevent. Of the various intestinal antiseptics, naphthalin seems the best for rectal use. Generally it darkens the urine but, as far as my observation goes, without irritating the kidneys or producing any other untoward effect.

From one to three injections, such as I have just described, should be given daily either in single or in divided quantities as indicated by the tolerance of the bowel. The colon should be irrigated every second day with hot water and turpentine or milk of asafetida.

In case of offensive or stercoraceous vomiting, both the stomach and the colon should be thoroughly washed out—repeatedly if necessary. Several times in acute peritonitis I have witnessed great relief from this procedure, and twice I feel positive the sav-

ing of life. It is a rational procedure, amply justified by practical results.—*Wallace A. Briggs, M. D., in Occidental Medical Times.*

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### AN EARLY SIGN OF TUBERCULOSIS.

The glistening eye of the consumptive has often been commented upon, as well as the pupil-state in many diseases, but there is a condition of the eyes which is quite constant in patients who present themselves in the physician's office or at the clinic and who make no mention of any symptom suggestive of a tubercular trouble, and in whom there are no evidences, either to physical or microscopic examination, of tuberculosis. I refer to a widely dilated state of both pupils; not a paralyzed pupil, but rather one which seems to be in a more or less constant state of dilation, due to some irritation along the track of the nerve fibres in the cilio-spinal region or perhaps an irritation of the sympathetic, brought about by some blood change associated with very early tubercular infection and not yet fully recognized.

I have repeatedly observed this condition of the pupils in persons who were apparently well; also in those exhibiting manifestations of a liver, stomach or intestinal disturbance, with no reason for suspecting tuberculosis; yet so frequently has tuberculosis followed at a later day that I have come to associate widely dilated pupils with incipient tuberculosis. Again and again I have made a note of the pupil condition in patients with typhoid fever, pneumonia, measles, post-operated surgical cases, etc., and so uniformly has tuberculosis developed in those showing dilated pupils that I now give a guarded opinion in prognosticating such cases.—*Thos. F. Harrington, M. D., in Journal of Tuberculosis.*

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### FOR THE TREATMENT OF SCABIES.

In the Hospital St. Louis, the patient is first scrubbed, none too gently, with soft soap for half an hour. He is then immersed in a hot bath and the scrubbing continued for another half hour. The following ointment is then rubbed in and he resumes his clothes and takes his departure—usually cured—at least he is seldom known to return. The ointment is as follows: R.—*Potassium carbonatis* 4 parts, *sulphur sublimata* 8 parts, *adipis* 45 parts. M. We imagine this is rough on scabies; it is also rough on the patient. Herein lies the solution of the dispensary evil. Give each one a hurry-up cure for his ailment on the above lines and

the poor general practitioner will notice an immediate increase in his business.—*Dr. Baldwin in Western Clinical Recorder.*

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In an article on the "Premature Casting Off of the Products of Conception, with Their Management," in the *Western Medical Review*, Dr. W. L. Downing formulates his treatment as follows:

If the fetus has recently passed, leaving membranes and placenta behind, you may be able to remove them with one or two fingers introduced into the uterus; possibly you may have to resort to placenta forceps and curette. Should any very perceptible amount of time intervene between passage of fetus and placenta, remove the latter with sharp curette and follow with irrigation.

Should you have reason to believe that parts of a decomposed placenta still remain in the uterus—in other words, that the uterus is already septic or about to become so—better do a thorough curettage at once, irrigating all the while.

Should your patient be not already septic, be careful that you do not make her so. Take nothing for granted; investigate for yourself.

Don't be timid, because timidity has cost many a good woman her life; buckle on a little more courage, and do early what you know to be right.

With the uterus empty and thoroughly contracted, what then? See that our patient remains in bed a sufficiently long time for the repair of all lesions within the endometrium and the proper involution of the uterus.



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## Editorial.

### PAGAN PRACTICES PARALLELED IN CHRISTIAN LANDS.

Take for example the recent history of the Martsolf family in New Brighton, Pa. On the evening of Jan. 3rd, Mr. Frank S. Martsolf, a well known citizen of that town, a carpenter by trade and in good circumstances, entered an undertaker's establishment to arrange for the burial of a dead child. The undertaker asked for the physician's certificate, when Mr. Martsolf replied that he

had none, as no physician had been called, and that the child Nancy Irene, aged 6 years, 2 months and seven days, had died of diphtheria. The coroner, J. K. White, being informed of the circumstances, made an investigation. He found that the child had been sick five days of malignant diphtheria, but the parents believing in Divine healing, had not called a physician, the Health authorities had not been notified, the house had not been quarantined, but persons had been permitted to come in and go out without precaution, many having no suspicion of the nature of the malady.

The coroner made out a certificate on which he wrote: "The parents of this child through their belief in Divine healing neglected to call a physician to attend the child while it suffered, and it died from malignant diphtheria."

A permit was issued and the child was buried.

The following week it was rumored that another child, Roy L., a boy of five years, was sick with the same disease and the rumor proved to be true. J. D. Martsolf and District Attorney H. R. Calhoun had a talk with the parents, but they refused to consent to have the child attended by a physician. They said they are Free Presbyterians and a part of their belief is the curing of diseases by faith. They acknowledged that the disease was diphtheria, but they would not have a doctor. They said if it was the Lord's will to take the boy as He had the girl, He might do so; neither would they stop anyone from entering or leaving the house. That night Dr. J. S. Boyd, who had been the family physician before the Martsolfs got the faith cure craze, visited them and tried for two hours to reason or persuade them out of their delusion, but to no avail. However, the doctor examined the boy and made sure he had diphtheria. The Secretary of the Health Committee and Officer Winters also tried their powers, but in vain. A police officer was placed on guard in front of the residence. Soon the Rev. Mr. Rader, a Free Presbyterian minister, and with him an elder of the same persuasion, arrived from New Sewickley township, and sought to enter the house. They insisted so strongly that the officer was obliged to take them into custody and bring them before the Burgess. At the Burgess' office the pastor declared that he had come in obedience to the Lord's command to anoint the sick child, and also that it was necessary that he have an elder of the church with him. The Burgess asked him if he was not afraid to expose his own children by visiting such a case. He said that if they were afflicted with the disease the Lord would care for them. He was asked why the faith treat-

ment had not availed anything in the case of Nancy Irene. The Rev. Rader said that he had not anointed the child, the disease had acted so quickly and he had not been summoned till the child was dead.

Why had not a physician been summoned? He said the Bible does not teach that a physician be summoned. The Burgess inquired whether the Bible teaches that people should assist in spreading disease broadcast. The pastor acknowledged that it does not, and he and the elder promised to change their clothes after they had visited the patient. As they had committed no offense, they were released. They spent a half-hour in the Martsolf house and then left town.

The second child, Roy L., died on Jan. 5. The baby, Lloyd K., and the father, Mr. Martsolf, were found to be suffering with the disease and the former family physician again offered his aid. To this the Martsolfs finally consented. The doctor found the baby's case far gone with grave kidney and heart symptoms, to which it succumbed. The father recovered. The fact that no physician had been called to attend the children, and that the nature of the disease had not been made known, raised a great storm of indignation in the neighborhood, and indeed nearly over the whole town. Borough Attorney Calhoun was requested to give an opinion as to what legal course should be pursued; and it is pretty sure that something would have been done, though perhaps not strictly in accordance with either law or Gospel to bring those parents to a sense of duty, if the children had not all died so soon and thus ended the sickness.\*

It is strange indeed if there is no law in the land to prevent such crimes as that of the Martsolf parents. It should be no difficult task to prove it a case of criminal neglect. It could be plainly shown that medical attendance in time of injury or illness is as much a necessity of life as food, clothing or shelter. If the police authorities could not see their duty in the matter, it might have been taken up by a Humane Society and tried before the proper court. The Health Department should certainly have power to enforce quarantine and compliance with other measures for preventing the spreading of a contagious disease; and, if the Board of Health or Committee of Health as it exists in New Brighton had carried preventive measures so far as to compel

\*For the facts of this account we are indebted to Dr. Kohler, of New Brighton, and the *Beaver Valley News*.



isolation of the sick or even enforced medical attendance, it is probable that public opinion would have sustained them.

Of course, there would have arisen a howl about individual liberty, especially about religious liberty—and here we come upon the main difficulty of the whole question. Neglect of the sick as practiced by the devotees of the faith cure, is only another form of the many crimes committed in the name of religion. The U. S. Senate has recently engaged in a struggle upon a question which has interested the whole country, regarding a crime no more shocking than this one of neglecting the sick, all under the name of a religious belief. It is astounding that such a practice as "faith healing" should be tolerated in this country for one hour. The fact that it is, is not at all flattering to our reasoning powers nor to our zeal as republican citizens. It is amazing to see the haze that gathers about a subject immediately there is a religious factor in it. And the peculiarity of the foggiess apparently surrounding the subject of the faith cure is that it steals a glamour from the Christian faith, a faith which dominates the religious life of our country and is held in high respect or unconsciously influences many who do not profess it. If the same conduct as that of which the faith healers are guilty was perpetrated in the name of some other than the Christian religion, how different it would at once appear. Suppose a Hindoo child is attacked by a crocodile and its pagan mother makes no effort to rescue it because the reptile is sacred or represents a god. She may pray and she may weep but she allows the monster to devour her child and says such is the god's will. The Christian world is shocked at such practices and sends missionaries to enlighten the heathen.

The child of a mother who calls herself a Christian is attacked by diphtheria, and the mother instead of making any effort with tangible means to fight off the monster and rescue her child, says the disease is a visitation of the Lord, and if the Lord wills, He can rescue the child, or if the disease destroys him, it was the Lord's doing.

Are not these cases about as nearly parallel as possible? What is the essential difference in the conduct of the two mothers? There is none.

Their conduct is the same and equally reprehensible. The cases are alike with the exception that the Christian mother substitutes a different deity. It will be argued that that makes an immense difference. Let us bring the illustration nearer home.

A negress in Louisiana sees her child wading in the bayou near an alligator. Instead of making a practical effort to rescue the child, the mother kneels down and prays to the Lord to deliver it from danger. What will be said of her conduct? Probably some persons will consider this case vastly different from the other and will admire her sublime faith. But the great majority of sane people will say that she ought to have called the child away or brought it away herself. What is the difference in the result in this case—practically none—the alligator gets the pickaninny. The negress is a fanatic the same as the Hindoo woman, and, if she voluntarily continued a practice which resulted in loss of life, she should be promptly taken in hands by the legal authorities.

Will any sensible person contend that diphtheria bacilli or other disease germs are more completely under the control of the Deity or amenable to prayer than alligators or other creatures?

They say it is all because of want of faith that diseases afflict us and that if people only would have faith enough diseases could not harm us—they would disappear—there would be no disease. Now, if faith can remove, or Divine power will, when called upon, remove disease, for instance a germ disease like diphtheria, surely the same means might be trusted to remove or subdue wild beasts. Is there any record to prove that of the thousands of Christians who were given to wild beasts in the Roman amphitheatres, any were miraculously preserved? Thousands of them were destroyed. Are those saints and martyrs to be accused of lack of faith?

In dealing by law with fanatics, not merely their motives should be judged, but the results of their practices; nor should the particular form of their religious enthusiasm blind us to the enormity of their crime or misdemeanor. The Thugs of India worship the Goddess Devi or Kali, by strangling human beings according to certain prescribed methods, a portion of the victim's goods being devoted to religious ceremonies, and the body burned with peculiar and minutely regulated rites. Now, if a religious belief causes a sacrifice of human life, what is the essential difference whether the murder is done in the name of Devi or of the Lord Jesus Christ? Would Thuggee—the practices of the Thugs, be tolerated in the United States? Not for an hour! Then neither should the practice of the faith healers be tolerated even though it is carried on in the name of religion. It is true that the latter do not choose and actively attack their prey; no, but they take Disease as a member into their brotherhood and allow this grim ally to se-

lect and destroy the victims, while they stand by and perform the religious ceremonies and prevent others from rendering aid to the stricken ones. Stripped of the gauzy garment thrown about it by our reverence for the Christian religion, partly obscuring its ugly features, "Christian Science" of the "faith cure" is as horribly barbarous a practice as any that has disgraced paganism since the days when mothers laid their babes upon the brazen arms of Moloch and left them there to burn. Picture to yourself those children suffering in the terrible and loathsome clutches of diphtheria, and those parents standing idly by witnessing the sacrifice, and even preventing efforts for their rescue. Suppose those children were attacked by a crocodile or other reptile and the parents behaved thus. Suppose they laid their helpless offspring upon the arms of Moloch—what would be done about it? They would have to stand trial either as to their sanity or for criminality. What shall be said of that pastor and that elder and their complicity in this crime? They are like the priests of Moloch, who performed their ceremonies and made noises upon various instruments to drown the cries of the infants while they were burning.

Where did these deluded creatures get their authority for the claim that God is better pleased that any person should die of a disease than use means well known to preserve them in life and health and usefulness? There is more religion and more common sense in that old saying that "God helps them that help themselves" than in all the utterances of Mrs. Eddy and her fellow pagans. The sooner sane citizens of every denomination or of no denomination brush aside the thin veil of a so-called religious belief and see "Christian Science" as it really is in all the ugliness of its criminality and the fantastic horrors of its insane delusions, the sooner will they take vigorous measures to deal with its devotees according to their practices—either as criminals or as insane. Their practices equal in atrocity those charged upon the heathen of bygone times and are a disgrace upon the civilization of today either Christian or Pagan.

KELLEY.

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### EYE-TESTING IN THE PUBLIC SCHOOLS.

For some time it has been evident that the schools contain many children whose eyes require the attention of the physician. These are cases whose parents, for one reason or another, either have not discovered the defect or, having done so, will not make



an effort to have it remedied. During the past five years several hundred of these cases have been examined and the parents notified. Many of them were at once taken by their parents to the family doctor and some, eventually, to the eye specialist. So much benefit accrued to the children that it was decided to extend the work this year so that the teachers, instead of examining particularly suspicious cases, should examine the eyes of all of the children in the city schools. At this date most of the teachers have completed their work and for the most part their reports show careful, accurate investigation. While mistakes are now and then made they are far less numerous than we had expected to find them. A second examination of several hundred of the cases by the supervisor has shown that the observations of the teachers in the use of the test type are, in most cases, essentially correct.

It is too early to say much about the results, but attention may be called to a few of them.

Medical attention has been called to very many cases of eye trouble which previously had remained unsuspected. This has been of special value in the many cases in which one eye was practically emmetropic while the other was from  $\frac{3}{8}$  to  $\frac{7}{8}$ . The eyes of 12+ per cent. of the children in one of the buildings were found to be in this condition. In scarcely any of these cases did the children or their parents realize that anything was wrong. In the upper grades many of these cases have been found in which one eye, through lack of use, is now of little value.

The teachers and many of the pupils have been brought into closer sympathy in very many cases as a result of this investigation. Teachers have appreciated, as never before, how a defect of the sight or hearing places a handicap upon some of their most earnest pupils which renders their best efforts rather unsatisfactory. Some results which heretofore have been attributed to laziness or stupidity are found to be due to the inability of the pupil to hear or see the explanations of the teacher.

Every case found abnormal is reported upon record blanks. These are kept on file for future use. In time these data will be summarised and placed in statistical tables. When the evidence is all in we shall have a good working basis for future instructions to teachers regarding the hygiene of the eyes of their pupils. In order to fit them to do this work intelligently and correctly the students at the Normal Training School are taught how to use the

test type and are given cases to test under the instruction of the supervisor.

In testing, Snellen's type, printed upon cardboard, are used. The suggestions regarding the testing, together with the blanks used, are herewith printed and serve to explain, in a general way, the *modus operandi*. In addition to the printed instructions furnished each teacher, the method of testing was demonstrated at teachers' meetings.

#### SUGGESTIONS FOR THE USE OF TEACHERS IN TESTING THE EYES AND EARS OF PUPILS.

##### VISION.

**THE USE OF TEST TYPES.** When the test is made, other pupils should not be present. The test letters should not be in sight except when used in testing a pupil.

Several pupils who are to be tested may be asked to remain after school. If it is not convenient to make the tests in the hall, hang the card in a good light in the room. All but one pupil may be sent to the hall or cloak room. Place the pupil at a distance of exactly twenty feet from the test letters. Cover the left eye with any opaque object, without pressing on the eyeball. Beginning with the large type at the top, direct the pupil to read all of the type with the right eye, from above downward. The twenty foot type should easily be read at the distance for that type (20 feet). If this can be done, the vision of the right eye is  $\frac{20}{20}$  or normal. But if the child cannot read these letters, the parent should be notified. Test the left eye in the same manner.

**SYMPTOMS.** Some eyes which can accommodate so as to read test type at the proper distance, are nevertheless defective. The following symptoms will assist in detecting such cases:

They tire easily, and often are red after work.

They itch or burn, and sometimes water.

Often they ache after work, or headache is present.

##### HEARING.

**GALE'S TEST.** Request the pupil to stand, chalk in hand, facing the blackboard. Dictate numbers, 1, 7, 9, 7, etc., as in calling the numbers of a telephone. The pupil should keep his face turned toward the board and write the numbers as they are called. The teacher should stand at the desk and speak in the tone of voice used in teaching. If the pupil does not hear well, advance toward him the distance of one seat and desk, and again dictate. If he does not then readily understand, advance another and an-

other, continuing to dictate numbers or letters, until you reach a place where your dictation is readily understood. The distance between yourself and the pupil is the distance at which he should be seated from your desk, in order that he may do satisfactory work.

**SUGGESTION REGARDING SEATING.** Have the pupils assume the active sitting position. Walk down the aisles and note the number whose feet do not rest squarely upon the floor. Supply them with blocks, and explain their use and value. Enter in your report the number supplied.

#### NOTES.

1. At the beginning of the year all suspected cases should be tested, and if a defect is found, the parents should be notified at once.

2. In case the parents neglect the case, it should be sent to the supervisor of hygiene, upon his visit to the building.

3. The name, age and grade of all pupils thought to be defective, should be entered in the teacher's report. If the smallest type the child can read correctly, is the 30-foot type, with the right eye, and the 40-foot type with the left, enter 30 under Right Eye and 40 under Left Eye. In other words, state what type, as expressed in the number of feet written above the type, the child can read correctly at a distance of 20 feet. In the hearing column record in feet the approximate distance at which the pupil responds correctly to dictation in Gale's Test.

4. While it requires some time and patience to make these tests, it will add so much to the ability of many pupils to do work that in the end much time will be saved. Many cases of incipient eye and ear trouble, and spinal curvature, will be prevented from becoming incurable.

L. K. BAKER.

#### TEACHER'S NOTIFICATION TO PARENT.

.....School, .....19....

Mr. ....

An examination of the eyes ears of your ..... shows them to be defective and not up to the standard necessary for the satisfactory performance of school work.

You should advise with your family physician as to the treatment, or the choice of the specialist whom you should consult, at an early date.

Respectfully,

.....

*Teacher.*



(To teacher.—Of the words—eyes ears—cross out the one not used.)

PARENT'S RECEIPT.

....., 19....

Miss .....

Your notification of the examination of my ..... eyes ears has been received. Respectfully,

.....

*Parent.*

(Parents are requested to sign the lower blank, tear it off and return it, at once, to the teacher.)

DEPARTMENT OF SCHOOL HYGIENE, CLEVELAND PUBLIC SCHOOLS.

REPORT OF TEACHER.

(To be used in connection with "Suggestions for the Use of Teachers in Testing the Eyes and Ears of Pupils.")

....., 19....

....., Teacher.

..... School.

..... Grade.

Name .....

Age .....

Sex .....

Vision.—R. E..... L. E.....

Hearing .....

Remarks .....

Total number of pupils, ..... Total number of pupils with defects of special senses, ..... Total number of pupils wearing glasses at the beginning of the year, ..... Total number of pupils wearing glasses at the end of the first term, ..... Total number of pupils who do not see well with their glasses, ..... Total number of pupils who do not hear well, ..... Total number of pupils using blocks, .....

SUPERVISOR'S NOTIFICATION TO PARENT.

..... School, ..... , 19....

Mr. ....

Upon examination I find that your ..... has  
.....  
.....

This is a very important matter and should receive the imme-

diate attention of your family physician and, with his advice, the attention of the specialist whom he may suggest.

Respectfully,

LEIGH K. BAKER, M. D.,  
Supervisor of School Hygiene.

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## **Society Proceedings.**

May L. Bassett, Medical Reporter.

CUYAHOGA COUNTY MEDICAL SOCIETY, JAN. 4, 1900.

The regular meeting of the Cuyahoga County Medical Society was held at the Cleveland Medical Library on the evening of Jan. 4th, the President, Dr. Bunts, in the chair. The minutes of the last meeting were read and approved.

Dr. Crile presented his paper, "Observations on Abdominal Sections based on four hundred operations." This paper appeared in the January number of the *GAZETTE*.

Discussion of Dr. Crile's paper.

*Dr. Tuckerman:* I was somewhat interested in the matter of clinical failures in these operations upon the abdomen and especially in the complete failures in the cases of neuroses, chiefly because I have had so many of these cases who came to me and wanted that I should do something for them, after they had been to numerous other physicians in town either before or after the ovariectomy was performed. Some of these cases come to us with pretty nearly every organ of the body removed or operated upon for some neurosis or other. I remember one case that was sent to Charity Hospital to have the ovaries removed, then sent down to the Lakeside to have something else removed, then to still another Hospital and had something more removed, and then the patient came to me asking for relief from the many distressing symptoms following all these operations, the first of which should probably never have been performed. I remember another case in which there was a history of specific infection. The case came to me and I advised against laparotomy, for from the look of the case the trouble seemed due to causes that could not be relieved by operation. She went, however, to some one else and they sent her out to the Charity Hospital, where she left her ovaries, and then she came to St. Alexis and bothered me during my whole service there last spring. As to the pathological symptoms,—the pain and disability,—they were worse than before the operation. The in-

dications for operation in that class of cases is not settled by any means, and I think there is a growing prejudice against it among physicians. There is another question about the sterility of the pus in these cases, and that is the disinclination of the gonococcus to grow except in its own natural habitat.

Examination of these cases may be made microscopically, but even if you do not get a growth from one of these tubes or abscesses you cannot swear that gonococcus is not present. I think that in attempts to cultivate the gonococcus fully 75 per cent fail where 25 per cent succeed. Examination of smears is also uncertain though you may not find a gonococcus present in a single smear you cannot be certain it is not present.

The utmost that you can be certain of by the culture test is whether cocci readily cultivated on artificial media is present or absent.

*Dr. Reich:* I am glad that Dr. Crile has touched the point of stimulation in his paper.

Stimulation with strychnia, if necessary, should be timely and used judiciously, and it is often *after* the operation that the patient is in need of the drug. We find the same true in pneumonia and typhoid fever. We have learned in these cases that the stimulation must be reserved until indicated and not feed or stimulate our patient in advance.

In the same way some physicians are over-zealous in stuffing their patients with mercury or the protoiodides as soon as they discover the primary lesions of syphilis, thinking thereby to abort the disease in its infancy. But they soon find, if their diagnosis of lues was correct, that the secondary lesions will appear despite their zeal and precaution. I have heard Professor Lesser of Berlin call special attention to this. "Never begin," said he, "with the syphilis cure until the secondary lesions make their appearance." The idea of beginning with the cure immediately after one sees the chancre is erroneous, for the medicaments cannot prevent the secondary manifestations, and besides if the patient has been taking mercury for some time his system has become immune, so to say, against the drug, and will not have the desired effect when sorely needed.

Therefore, wait till you are quite sure you have lues before you, and then go ahead with your treatment.

*Dr. Scott:* I would like to ask if in operation for hernia, Dr.



Crile has observed hernia as a result of the division of the nerve supplying the rectus muscle.

*Dr. Bunts:* I wish to present this specimen in connection with Dr. Crile's cases. Last May I operated on a patient who had chronic ovaritis and salpingitis, and both she and her husband insisted that as much as possible of the ovary be left behind because they desired a child. The husband was a physician. We found the left ovary badly diseased, and the right one somewhat so,—it was enlarged a little but not exactly cystic. It was my judgment to remove it, but the husband insisted on its being left, and said they would take the risk. We left practically a third of the enlarged ovary, a piece that, allowing for its enlargement, was not as large as a normal ovary. This was last May. Last week she came to the city to have another examination, and I found a floating mass in the right side. She had been suffering a great deal and was using morphine in such doses as to be in danger of becoming a morphine-eater. I operated and found a cyst. All trace of the first operation was gone. We found a little ovarian tissue still remaining, but like most of these Graafian follicular cysts the ovary was nearly gone. The most remarkable thing about the case is the rapidity of the development of this cyst.

I would like to say one word with regard to deaths from laparotomy. I agree with the Doctor as to what he says about statistics after operation. If you take the records of one gynecologist and one surgeon operating upon the same kind of cases, and granting equal ability and advantages for operation, the records will depend upon the class of cases they get. Sometime since I was very much interested in hearing Mr. Holmes' lectures on laparotomies as his history of cases extended over many years, and his statement was, that up to 1889 fifty per cent of the laparotomies had died in the hospital with which he was connected. This was a strong statement and he acknowledged it. He said, however, that we must consider that his hospital gathers in a class of cases that have reached a point where operation becomes imperative,—cases that have become so urgent that they must be operated or death will ensue, and therefore cases that are liable to have a fatal issue.

In regard to stimulation, it seems to me that it is a matter to come under consideration of the operator rather than the anes-  
thetizer.

I feel that not to give stimulants when needed for fear that

they might sometimes be very urgently needed, would be like not ligating a gunshot wound of the popliteal artery for fear that the femoral might be wounded at the next shot and no ligature be at hand to stop its hemorrhage. The rule, it seems to me, should be that the patient should have stimulation whenever it becomes apparent that he needs it.

*Dr. Crile:* Regarding Dr. Tuckerman's point,—it is well taken. Dr. Fitzgerald makes the microscopic examination and I think he always makes two tests, not in all, perhaps, but he does in all cases in which a gonococcus infection is in question. It is surprising how many abscesses are sterile, the infection having been destroyed, the abscess cavity is practically sterilized. I have found that the use of ovarian extract in many cases may be obtained, and again it will prove an entire failure. I have been unable to determine the cases that will yield to this treatment.

*Dr. Smith:* Are these cases relieved by the use of the extract from the symptoms following operation or the original symptoms?

*Dr. Crile:* Some cases are. I think that I have one of these cases now, Doctor Tuckerman, and I will send it back to you! I am not pessimistic on this subject, but I do think better judgment might be used. In reply to Dr. Smith I will say that I have faith in therapeutics, but I believe that every patient has a given amount of potential energy, and it must be carefully used up by drug stimulation. I know that many surgeons give strychnia before operation and during it. Any part of the potential energy drawn out by drug effect diminishes by so much the total amount available for tiding the patient over the stress of operation. Falling blood pressure may be partially or wholly restored with normal saline solution except in cases in which there is a break down in the vaso-motor mechanism.

I have not seen a case of hernia from paralysis of the rectus muscle, but I have seen bulging of the wall.

As to what Dr. Bunts has said, it is along the line of my own thought and this question must be personal and decided according to the case at hand. As to the statistics the question is a difficult one. If you have 93 cases consecutively which recover without any complications, it is a great temptation to report it and say nothing about the fatal 94th. With regard to the use of catgut an abundant experience with the Kummel method introduced by Dr. Bunts leaves but little to be desired.

*Dr. Tuckerman:* On the question of statistics,—I think we

many times forget to reckon the co-efficient of error in these figures. You know that co-efficient varies inversely as the number of cases, and it takes a list of ten thousand similar cases to reduce the co-efficient of error to one per cent.

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## Correspondence.

NEW YORK, January 22, 1900.

*To the Editor of the Cleveland Medical Gazette:*

My Dear Doctor:—While I must naturally concede that the physician who desires to be well-informed, should promptly read all of the foremost medical publications, I am obliged to confess that the December issue of the CLEVELAND MEDICAL GAZETTE was not seen by me until to-day. I might, indeed, have been deprived thereof for some time, had Dr. B. T. Whitmore of this city not called my special attention to the Editorial it contained on pages 83 to 90, signed by Dr. Kelley.

I would be astounded at Dr. Kelley's expose of the undesignated practitioner who ornamented (?) my paper on "The Proofs of Cure of Gonorrhœa," by heading it with his name as the author thereof, if this were the first instance of the kind. But one can grow accustomed to anything. Being constitutionally opposed to wrangling, and needing all my time for study and work, I pay no attention to such treatment, but content myself by applauding the valiant manner in which the integrity of the profession is defended by such colleagues as are you and your associates. That you, without knowing me more than casually, have therein defended me so well, puts me under obligations to you, which it will be impossible to repay except in gratitude.

A singular unanimity of method of those who appropriate the work of other writers, seems to merit some attention. The first writer desiring to show other practitioners the methods with which he succeeds, is careful to direct his best efforts to making the details thereof clear. Those who bodily "take" his work, omit just those parts and thus thwart the very purpose for which the original article was written. It then loses value for the large body of practitioners and serves only as an advertisement for the person who "annexed" the paper. Therefore, such an explanation as you give of the matter, can serve the profession only as a warning against the value of the article *stolen*. Pardon the harsh verb, as my stock of euphemisms is exhausted above.



Another point, however, I would like to lay before you. The same article furnished the substance of the chapter with the same title in the book on "Gonorrhœa, its Complications and Sequelae," now being published by Messrs. Wm. Wood & Co.

Those of your many readers who may have met the work (?) of the individual whom you exposed, might, when reading this chapter, look upon me as having robbed the Cleveland physician of the article you so ably dissected. The same may happen to another chapter, whose contents were in November, 1899, republished by another physician from an article of mine which appeared in January 1898. In this, my original work and ideas were also given the profession as original with him.

Amidst the many defects the book on Gonorrhœa contains, it certainly will not reveal either the thoughts or works of others without giving full credit to the authors thereof; this is not prompted by honesty alone, but by that self-respect without which decency cannot be attempted.

Again thanking you for the services rendered to the profession and to me, I am, dear Mr. Editor, most respectfully yours,

FERD. C. VALENTINE.

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LONDON, ENG., January, 1900.

London in war time appears, to the casual observer, but little different from the ordinary. Whether making the rounds of the Hospitals or taking in the sights, one sees very little of the immense preparations going on for the upholding of the power of the British Empire.

London is a large city. Larger and greater than one can realize until he wants to get somewhere and "get there quick." Then he finds out, to his sorrow, that he makes haste slowly,—altogether too slowly for a pushing Yankee, used to rapid transit, the lumbering double-decked London 'bus and the trolley car being quite comparable to the tortoise and the hare. So it is that unless you go where the war excitement is you will see nothing of it.

But once go down to Whitehall or Downing streets, where the government offices are, and where lists of killed and wounded are posted, and look upon the anxious, tear-stained face of a richly dressed lady, jostling with a wan, careworn little woman, hugging tightly a babe, covered by a tattered shawl; each pushing and shoving toward a bulletin which quite probably contains the name

of a brother or a husband, an "Absent-minded Beggar," as Kipling puts it, killed in action, and you will wend your way home with a realization of what "Horrors of War" means. But I must cease this sentimentality and write more of medical affairs.

The preparations being made to care for the sick and wounded are probably the greatest ever made by any nation, not excepting our own Spanish war.

Hospital trains and hospital ships are being sent out one after the other, and all are fitted up remarkably well, for the English. I add the latter phrase because the English and European ideas of comfort and convenience is very crude, in fact I might almost say that it seems to be a lost art. A Pullman hospital train such as we could make up in a few hours, would be an impossibility here. A new hospital train which has just been completed has "continuous corridors," each car is heated by a stove (no steam heating), carries a "supply of water," has a refrigerator and filter, and the rear car is fitted with a kitchen, in fact the train is "very complete." A large number of these trains is being sent to the front. Hospital ships are already bringing home the sick and wounded. One excellent feature about all these preparations is that everything is thrown open for inspection and criticism. There is nothing covered up, and I venture to prophecy that it will reduce the probability of scandals and future investigations.

The lessons we learned in our little Spanish affair about Mauser bullet wounds are being duplicated by the British. The wounds are clean-cut, with no laceration or mangling of the part. The entrance wound is about as large as the end of a lead pencil, and the bullet very generally takes an oblique course and emerges from the body by another very small opening. The astonishingly large per cent of recoveries of apparently fatal cases continues the same in this as in our own war, gunshot wounds of the abdomen, with perforation of the intestines, very generally ending in recovery in 20 to 30 days.

Besides the Mauser the Boers use the Martini-Henry rifle, which makes a large and uglier wound.

The Medical Corps of the British Army has already suffered heavy losses from the long range and unerring eye of the Boer riflemen, and it appears that the Red Cross flag does not carry the protection it should. The International Medical Congress is to meet in Paris in 1900. Are there any of the readers of the *GAZETTE* expecting to go? If so, will they, for the sake of their

pocketbooks, give up any such wild idea. I understand that it is even now difficult to obtain lodging in Paris during the Exposition. It has become so evident that Paris will be unable to care for her guests, that the Secretary-General of the Medical Congress has just completed arrangements whereby he can put 800 cots into several halls, for which he expects to charge \$1.10 per cot for a nasal concert of eight hours, more or less. Don't go.

HENRY J. HERRICK, JR.

27 Upp. Bedford Pl., Russell Sq., W. C.

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## Notes and Comments.

**Dr. Charles B. Parker** was confined to his house by a severe cold during the first week of February.

**Dr. George W. Crile** was married to Miss Grace McBride on February 7th. Dr. and Mrs. Crile will spend the next three months on a trip to Japan.

**Dr. William E. Lower**, the efficient colleague of Dr. Crile, will look after the practice of the latter during his absence.

**Dr. H. J. Herrick, Sr.**, who has been in poor health lately, is at Jackson Sanitarium, Dansville, N. Y., and is much improved in health.

**Dr. Calvin Shaw** was on the sick list during the latter week of January and first week of February.

**Dr. W. A. Phillips**, Medical Department Western University, Class of 1888, was elected President of The Nevada State Medical Society at Virginia City, Jan. 8, 1900, (semi-annual meeting), for the year 1900.

**Dr. V. C. Lucas**, of 375 Jennings avenue, is to leave the city about the first of March for a tour of a year or more through Mexico and South America.

**Dr. Ampt** will take charge of Dr. Lucas' practice during the latter's absence from the city.

**An English medical man** has driven his motor carriage 5,000 miles in a year, at a total running expense of \$130.

**Dr. S. P. Schroeder** advises operation in cases of gall stones when the conditions are as follows:

1. In all cases of gall-stone colic where the jaundice lasts four weeks.



2. In all recurring attacks of hepatic colic followed by fever, and where, during an attack, the gall-cyst is enlarged.

3. In all cases of constant enlargement of the gall-bladder with or without jaundice or fever.—*Interstate Medical Journal*.

**Dr. Lewis Schooler**, in a well-written paper on "What becomes of the medicinally treated cases of appendicitis," in the *Charlotte Medical Journal*, sums up his arguments thus:

"In conclusion, then, patients who are treated by means of medicine only, either die under such treatment, or are later cured by operation. To the above there should be noted a single exception, viz.: Those cases which are spontaneously cured. This occurs by rupture into the bowel, vagina, bladder or externally.

"Instances of this method of cure are familiar to all. It is therefore singular that in view of such familiar occurrence that these medical gentlemen do not take the hint that nature is so persistently urging upon them and comprehend more clearly the fact that removal of the offending cause—organ and product—is the only rational procedure. It is the only one that is approved by nature, pathology, observation and science.

**Evangelist D. L. Moody on Physicians.** Mr. Moody has the name of getting off a lot of good sense in his sermons. He believes in a practical religion; in a religion of truth and self-sacrifice; in a religion of noble aspirations and noble deeds; in a religion that elevates the individual, the community, and the nation in every way that is good. During the past week one of his alleged co-workers acknowledged having endorsed the notorious Dowie, and not only this, but did not deny that he had allowed one of his children to die of diphtheria without calling in a physician. In one of his sermons Mr. Moody took occasion to let this alleged co-worker know that the saving of souls and the healing of the body were two entirely different propositions, and among other things he said: "I do not believe that doctors are devils. The noblest profession outside of the ministry is that of medicine. Never yet in all my years of work have I called upon an able doctor, telling him of the sickness and need of some poor friendless person, that he did not at once go to the rescue, without money and without price. Some of the noblest men I ever knew have gone out as medical missionaries, devoting their lives to doing good with the skill and healing medicines the Lord has conferred upon them. And these men are called devils! God have mercy upon the man who says so—God forgive the man who holds such

beliefs! God heals, and God heals through doctors and through medicines. Do not be carried away by the raving of fanaticism. We have a new 'ism' in America about every year—beware of the 'isms!' What would I do if I fell sick? Get the best doctor in Chicago, trust to him, and trust to the Lord to work through him! The doctors have done wonders as their knowledge has grown—they have reduced the dangers of death from diseases that once slew all they touched—and the doctors, if God helps them, will yet find a way to stop the ravages of other terrors!"—*Journal American Medical Association.*

### **A Considerable Percentage of our Milch Cows are Tubercular.**

To what extent the use of tuberculous milk is accountable for tubercular diseases of children I am unable to state. That it is an important cause no one will deny. To prevent the sale of tuberculous milk we must stop the use of tuberculous cows for the production of milk. This has been attempted in some cities and states, but with only partial success. With the tuberculin test it is possible to detect the presence of tuberculosis in the cow in probably 96 to 97 per cent of all cases, but the test does not show to what extent the animal is diseased. No animal with incipient tuberculosis should be used for the production of milk. The State, under its police powers, has the right to provide for the inspection of all milch cows, and to prohibit the use of those shown to have tuberculosis. It may condemn and slaughter such animals for the protection of the public health.

A city may require the dairyman to furnish satisfactory evidence that all cows producing milk which he sells in such city are free from tuberculosis or other dangerous communicable disease. In the case of the city of Minneapolis the Supreme Court of Minnesota decided that the municipality could require that all cows furnishing milk for that city should be shown to be free from tuberculosis by the tuberculin test, and that this is a reasonable method for detecting this disease. We can never hope to stamp out tuberculosis among milch cows in this manner. We may lessen the number of cases, but so long as the conditions which produce bovine tuberculosis remain we will never eradicate the disease from our herds. Cows under natural conditions, in the open, rarely have tuberculosis. It is the dark, filthy, unventilated cow stable that is principally responsible for the spread of tuberculosis among dairy cattle.—*C. O. Probst, M. D., Secretary State Board of Health, in Medicine.*

**A Black List of Non-Paying Patients.** The physicians of West Chester, a near suburb of Philadelphia, are reported to have formed a mutual agreement by which it is proposed to keep a general "black-list" of people who will not pay their doctor's bills. It would seem that West Chester suffers to a great degree from that very common pandemic, the leading symptom of which is disinclination on the part of the individual to remunerate his medical attendant, and that the doctors of this town hereafter agree to refuse medical services to all persons who by their past actions are classed among those able but unwilling to pay just accounts for physicians' attendance.—*Medical News*.

**When There is Active Congestion of the Ovaries and Uterus,** painful menstruation, owing to the excited state of central nervous mass presiding over these pelvic organs, these symptoms are finely controlled by bromide of sodium. Should the case prove stubborn, I add full doses of viburnum prun; the two are helpful to each other in these pelvic troubles and appear to act as sedatives to the organs involved. Bromide of potassium and bromide of ammonia combined in equal quantities appear to me to afford far better results in treating many diseases of the nervous system than either alone. In most of these nervous diseases, attended by pain in some organs, in restlessness, or dry cough, or cough more moist and dependent on irritation of the laryngeal nerves, or of the vagus proper, especially the fibres that supply the lungs and stomach, I have found bromide of sodium and the ammonia salt well adapted to controlling and curing the cases. Some cases of sleeplessness, in nervous affections, face pale and heart weak, I like the ammonia salt, to which I add collinsonia with excellent results, inasmuch as this medicament is a fairly good heart tonic and helpful to the bromides.—*Jos. Adolphus in Medical Times*.

**The Bromides** are frequently made use of in simple insomnia and are comparatively harmless preparations. They produce a sedative effect upon the cerebral functions and allay irritability of sensory nerves. They affect the circulation through their action upon the cardiac ganglia. Nevertheless, when too long continued they impair digestion, impoverish the blood, and produce the unpleasant phenomena of bromism. Potassium bromide in large doses causes dilatation of the right heart, with reduction of arterial pressure. Strontium bromide will generally be found preferable in insomnia dependent upon disease of the heart or kidneys and accompanied by gastro-intestinal disorder.



In cases of obstinate sleeplessness, particularly when accompanied or caused by pain or spasm, cannabis indica will afford excellent service. I have not infrequently observed it succeed in such cases after the failure of opium. It is likewise a valuable *succedaneum* to opium in cases where the latter cannot be tolerated. In painful affections of the stomach and bowels causing sleeplessness, and in uterine and ovarian disease, this remedy has a remarkably favorable action.—*John V. Shoemaker, M. D., L. L. D., in Medical Bulletin.*

**Strychnine.** It is a curious fact that strychnine certainly was until very lately, and probably is still, almost altogether manufactured in the United States; this growing out of the circumstance that the amount of strychnine used in the practice of medicine is a mere bagatelle compared with that which is employed upon the American frontier for the destruction of wild animals. Strychnine may therefore be considered an especially American drug, and it is fitting that the increasing recognition of its value in medicine which has come of late years should be largely of American origin. In this article I want to discuss briefly the dose that should be used of the drug; for unless it be alcohol there is scarcely any other drug whose proper doses vary so much.

Very commonly strychnine is given in too small doses to produce the effect it is capable of. One-sixtieth of one-fortieth grain of the alkaloid is of very little value even as a simple tonic, except in persons of abnormal susceptibility. I have habitually given, for many years, the tonic dose as one-twentieth grain three times a day, and have never seen a case in which it produced anything like serious symptoms. In nervous females such doses will sometimes cause increased nervousness, or perhaps sleeplessness. In a very few cases that I have met with, as an idiosyncrasy even the smallest doses of strychnine cause vomiting. Very frequently it is better in the use of the drug to give none of it after 3 or 4 o'clock in the afternoon, and then secure the patient from wakeful nights.

As a general and respiratory stimulant strychnine is very valuable in acute pulmonic diseases, but here in order to be effective it should be given in full dose at short intervals. One-twentieth of a grain hypodermically, every four hours, in a pneumonia or in a low fever, is only moderate dosing, and especially do the old bear strychnine well. Their nerve centers are evidently so hardened by the vicissitudes of years that they are only to be affected by inordinate stimulation.

A rare condition in which strychnine has seemed to me to act almost as specifically as quinine does in intermittent fevers, is that form of subacute lead poisoning in which the symptoms closely resemble those of acute poliomyelitis; differing from them, however in that they occur in the adult; that they involve almost the whole body, and that they attack the sphincters as well as the muscles of voluntary life. An almost universal paralysis with rapid wasting of the muscles, appearance of reaction of degeneration, and involvement of the sphincters, constitute the series of manifestations of the cases under discussion.

Another condition in which strychnine is often of the greatest service is chronic alcoholism, and especially in those forms of chronic alcoholism in which the mental symptoms are pronounced and take upon themselves not the shape of a delirium tremens, but of a maniacal dementia; although in delirium tremens strychnine is often of the greatest service.

Then, again, there are certain cases of organic heart disease in which, in some way at present inexplicable, strychnine is of immense service. I have never been able to determine certainly from the symptoms of a cardiac case whether it was or was not one to be especially benefited by massive doses of strychnine, neither in a discoverable lesion, nor yet in the symptoms themselves. But although abnormal slowness of beat does seem to be a distinct indication for the use of strychnine, only by the therapeutic test does it seem to be possible to decide the relations of any individual case to the alkaloid.

In all cases spoken of in the last paragraph it is essential to give the strychnine to the point of physiological toleration, or, rather, non-toleration. Twenty-five years ago I was in consultation in a case in which the feebleness and exhaustion following an acute pulmonic attack seemed utterly unconquerable. After the thing had been going on for some weeks, owing to a misunderstanding between the nurse and the physician, four doses of strychnine were given at one time and repeated in four or five hours. Shortly after these doses violent convulsions came on, not severe enough to urgently threaten the life of the patient, but to alarm everyone greatly. The next day the patient was practically convalescent; the exhaustion and symptoms which had dragged on for weeks, under the administration of the ordinary therapeutic dose of the drug and of other tonics, nursing, stimulants, etc., was practically put an end to at once by the toxic dose of the strychnine.

As illustrative of the matter under discussion, I may mention two cases which have occurred in my practice during the past spring. One was the case of a saloonkeeper, who was brought to the University Hospital from another hospital, where he had been treated for six or eight weeks for alcoholic insanity or dementia; the man's physical condition was that of chronic alcoholism, while mentally he was a jabbering idiot, giving no evidence of knowing where or who he was, talking incessantly and irrationally. He was put in bed, where he was kept by the nurses during the day and by straps at night, and the order given to the resident to administer strychnine at intervals of six hours, hypodermically, increasing as rapidly as it could be done. This treatment was very earnestly and very boldly carried out by the doctor; within two weeks the man was taking three-quarters of a grain of strychnine a day hypodermically, was rational, and practically convalescent.

The second case was seen in consultation in private practice. Mr. — was a man of about 64 years of age, suffering from mitral insufficiency, of which the origin was in an obscure and distant past. The valvular lesion was, however, known to have existed for twelve years, and probably went back nearly thirty years to an acute attack of rheumatism. The patient had paid no attention to himself until about five months before I saw him, when he had a sudden anginose attack so severe that he lost consciousness and was pronounced by his physician dead. From that time on he had had, at short intervals, severe attacks of heart failure, not attended with much pain, but with excessive weakness and breathlessness, and a badly failing, very slow pulse, the rate usually being about 50. When I first saw him he was in bed, where he had been for weeks, unable to feed himself without bringing on an attack; life being maintained apparently only by the most rigid quiet. The cardiac murmur was distinct; the diagnosis absolute, except that there was some doubt whether there was, in addition to the insufficiency, also stenosis. The impulse was exceedingly weak, the pulse very irregular and feeble. Digitalis and strophanthus both had been tried. The digitalis treatment, however, was thoroughly re-tried, the drug being given at various times in small and in enormous doses, in every form and method of administration, and always doing harm rather than good. Strophanthus was then tried, and, while it seemed to suit the patient a little better than did digitalis, accomplished nothing. The patient was then put upon strychnine, which was rapidly in-



creased and given both by the mouth and hypodermically. At one time Mr. — was violently tetanized, owing to the nurse unwittingly giving a hypodermic injection a few minutes after his wife had administered a dose of strychnine by the mouth; but the symptoms readily yielded to remedies and the paroxysm seemed to do good rather than harm. During many weeks the object of the treatment was the keeping up of a perpetual chronic poisoning by strychnine. After Mr. — had so much improved that it was considered safe to allow the professional nurse to leave, the strychnine was given by the mouth, under the supervision of his wife.

A solution was made, one minim of which represented one-sixtieth of a grain of the alkaloid, and for weeks together eight minims of this solution were taken six times in the twenty-four hours, that is, during the twenty-four hours forty-eight-sixtieths (4-5ths) of a grain of strychnine were given by the mouth. Almost the whole time there was pronounced rigidity of the back and limbs, with markedly excited reflexes. The patient did not seem to become accustomed to the use of the drug, and after some weeks this condition of rigidity was so irksome that the dose was reduced to half a grain of strychnine a day. From the very beginning of the strychnine treatment the effect upon the circulation was very pronounced, and now Mr. —, who before the treatment had been unable to turn himself in bed without bringing on an attack, gets up, dresses himself, goes about the house and up and down stairs at will, moves his chair from one side of the room to the other, and lives a comfortable though still semi-invalid life. His pulse is fairly regular and strong, and for several months there has been no attack of cardiac failure.

Whenever strychnine is being pushed very rapidly and actively it should be given hypodermically. The maximum effect of such a dose is probably felt in about twenty minutes after its administration, and its influence probably lasts six hours, although it may be considered to be nearly gone at the end of four hours.—  
*Dr. H. C. Wood in American Medico-Surg. Bulletin.*

**Relative Toxicity of Cocaine and Eucaine.** 1. The action of cocaine is inconstant; one never knows whether the symptoms occasioned by like quantities of the drug, in animals or individuals, under like circumstances, will be similar or dissimilar.

2. The action of eucaine is constant. The symptoms occasioned by the use of like quantities in animals under like circum-

stances, and so far as my experiments have gone, in different individuals also, are the same.

3. The first action of cocaine on the heart is that of a depressant, and on the respiration it is that of a mild stimulant, the after-effects being, on the heart, that of a decided stimulant, and on the respiration, that of a decided depressant.

4. The first action of eucaïne on both the heart and respiration is that of a stimulant, the after-effects being that of a decided depressant.

5. Cocaine causes death in animals by paralyzing the muscles of the respiratory apparatus, the heart's action continuing in a feeble way for a brief period after breathing ceases.

6. Eucaïne causes death in animals by paralyzing the muscles of the heart and of the respiratory apparatus, they ceasing to operate simultaneously.

7. Eucaïne in toxic doses nearly always causes nausea, and occasionally vomiting.

8. Cocaine is much less nauseating, and scarcely ever causes vomiting.

9. Eucaïne is decidedly a diuretic, causing renal discharge in a majority of instances in which a toxic dose is used.

10. Cocaine is not a diuretic to any appreciable extent, renal discharge having occurred in only one instance in connection with all my experiments.

11. The pupils of the eye, in nearly all cases of cocaine poisoning, do not respond to light, and are more or less bulging from their sockets.

12. The pupils of the eyes in most cases of eucaïne poisoning do respond feebly to light, and rarely ever bulge from their sockets.

13. The action of toxic doses of eucaïne is more like that of a paralyzing, tetanoiding, convulsion-producing agent, than it is like an anæsthetizing one, the plantar and cremasteric reflexes nearly always responding.

14. Toxic doses of cocaine cause general anæsthesia in connection with the other symptoms in the majority of cases.

15. True tetanus, of all striped muscles of the limbs, and Cheyne-Stokes' breathing nearly always occur with the use of cocaine, but seldom does either occur when eucaïne is used.

16. Cocaine is at least three times more toxic than beta eucaïne, and alpha eucaïne is as toxic as cocaine.

17. Boiling does not destroy the efficacy of cocaine, but it

does modify it, and boiling in no degree lessens the efficacy of eucaine.—*A. H. Peck, M. D., D. D. S., in Dental Brief.*

**The Sterilization of Instruments with Boiling Distilled Water.** Dr. W. K. Roberts (*Journal of the American Medical Association*, December 16th) says, as a result of a series of experiments on the sterilization of cutting instruments, that if our ordinary hydrant water was used the edge of a knife was ruined, and in fact the whole instrument was damaged. The addition of soda to the water prevented the latter trouble, but only slightly lessened the harmful result to the edges. Rain water and the condensed vapor of the artificial ice establishments yielded less disastrous results, but still a knife boiled in these solutions, even with the addition of various preparations of sodium or potassium, was unfit for delicate use. As a consequence, inquiry of a large number of general surgeons elicited the information that, while instruments in general were usually prepared for operations by boiling, knives were simply scrubbed carefully, or scrubbed and dipped in alcohol. The efficiency of alcohol as a disinfectant has been so frequently questioned that its use seems almost superfluous.

The author's experiments proved that not only might instruments be safely boiled in distilled water a sufficient length of time to become sterile, but also, if distilled water was used in a sterilizer that was free from oxidized metal, the vapor and steam thus generated could be made use of for the preparation of instruments, dressings, and other appurtenances of an operation without harmful results to any of them, which would seem to be a convenience and to confer a simplicity greatly to be desired.—*New York Medical Journal.*

#### **A Case of Gonorrhea is Cured Only When:**

1. The normal urethral mucus shows no gonococci.
2. After the use of a genito-urinary irritant the excess produced shows no gonococci.
3. A condom specimen contains no gonococci.
4. An examination of the urine shows it to be free from shreds, filaments, flakes and granules.
5. The expressed contents of the prostate and seminal vesicles are free from infection.
6. The urethroscope shows a healthy urethra.

These are the important points in deciding a cure; no one is certain of itself, but taken together and giving a negative result prove that the case has been cured.—*Dr. W. H. Prioleau in Northwestern Clinic.*



## Counter-Irritants.

The professor of natural science at Ann Arbor was discussing the process of fertilizing plants by means of insects carrying pollen from one plant to another, and told them, after Darwin, that the old maids were the ultimate cause of it all. The humble bees carry pollen, the field mice eat the humble bees. Therefore, the more field mice the fewer humble bees and the less pollen and variation of plants. But cats devour field mice, and old maids protect cats.

Therefore, the more old maids, the more cats, the fewer field mice, the more bees.

Hence old maids are the cause of it all.

Therefore a Sophomore with a single eye-glass, an English umbrella, a box-coat, with his "trousers" rolled up at the bottom, arose and asked: "I sa-a-y, professah, what is the cause—ah—of old maids, don't you know?" "Perhaps Miss Jones can tell you," suggested the professor. "Dudes," said Miss Jones, sharply, and without a moment's hesitation.

There was silence in the room for the space of thirty seconds, after which the lecture was resumed.—*Morning Star*.

## They Took a Relapse.

*Disheartened Missionary* (returning to his field after years of absence: "Oh, unhappy men, you have lapsed into error and darkness and paganism again!")

*Chief Heathen* (apologetically): "Well, you see, after you went away a Catholic missionary came along and told us the bad place was full of Methodists, and so he scared us into his communion; then he went away and a Presbyterian came along and waked us up on regeneration, adoption, and election, and we joined his church; then an Episcopalian came and we burned our Westminsters and stocked up on prayer-books; then he left and a Baptist landed and walked us into the water and baptized us right, and we'd just about got settled when a new Congregationalist came over and told us that so long as we were heathen we had a dead sure thing of going to heaven; but if we became Christians we had to walk mighty straight or go to the everlasting bonfire. So we ate him up, burned our Bibles, and resumed business at the old stand. Boys, put the parson in the cage and fatten him up for Thanksgiving day.—*Brooklyn Eagle*.

Charles Dudley Warner says that the difference between the "faith cure" and the "mind cure" is that the mind cure doesn't require any faith, and the faith cure doesn't require any mind.—*Albany Medical Annals*.

When the eloquent divine, the Rev. Thomas Burke, was traveling through this part of the country delivering lectures nightly in crowded halls, he was accosted on a train one day by a man who wanted evidently to be able to say he had conversed with

the much talked-of clergyman. He approached the priest saying: "I understand you're the famous Father Tom Burke."

"I'm Father Burke," was the reply.

"Well, now, you know, Father," continued the man, thinking he had a subject productive of conversation, "I don't believe in purgatory."

After this brilliant challenge he waited. Without seeming to be very much interested and in a calm tone of voice, the great Irish wit said, "Well, go to hell then."

### When it is Good to be at Home.

"Well, Maggie," asked a teacher of a little girl, "how is it you are so late this morning to school?"

"Please, sir," was the reply, "there wis a wee bairn cam' to oor hoose this mornin'."

"Ah!" said the teacher, with a smile; "and wasn't your father very pleased with the new baby?"

"No, sir; my father's awa' in Edinburgh, and dinna ken aboot it yet; but it was a guid thing my mither wis at hame; for gin she had been awa', I wadna hae kent what to dae wi' it."—*Sanitarian*.

### Naming Twins.

A recent baptismal narrative told at a dinner table is of a negro woman who brought forward twins.

"Their names?" bent over the preacher, in inquiry.

"Dis one is Bigamy, after his paw, and dis one is Eczema, after her maw."—*New York Evening Sun*.

### The Difference Explained.

Rollo: "Tell me, pa, is there any difference between common salt and chloride of sodium?"

Mr. Holliday: "Yes, Rollo, a great difference. Salt is 2 cents a pound, at the grocer's, while chloride of sodium is 50 cents a teaspoonful, at the druggist's."—*Boston Transcript*.

### Big Words to a Small Witness.

A young lawyer from the North (The Sanitarian) on beginning practice in Virginia, in the sixties, questioning a colored witness, asked:

"Did the defendant knock the plaintiff down with *malice prepense*?"

"No, sir; he knocked him down with a flat-iron."

"You misunderstand me, my friend: I want to know whether he attacked him with any evil intent?"

"Oh, no, sir, it was outside of the tent."

"No, no, I wish you to tell me whether the attack was at all a free concerted affair."

"No, sir; it was not a free concert affair—it was at a circus."—*Exchange*.

# THE Cleveland Medical Gazette

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## Original Articles.

### A CLINICAL AND PATHOLOGICAL REPORT OF TWO CASES OF GENITAL TUBERCULOSIS.\*

BY HUNTER ROBB, M. D.

Professor of Gynæcology, Western Reserve University; Gynæcologist-in-Chief to Lakeside Hospital, Cleveland, Ohio.

Since the discovery by Neisser in 1879 of the micrococcus gonorrhœa or gonococcus not a few gynæcologists have shown a remarkable readiness to refer nearly all inflammations of the tubes and ovaries to its agency. That this organism does play an important part in the etiology of these affections is certain; but it must be remembered that there also exist other conditions which simulate very closely those induced by gonorrhœal infection and which can only be differentiated from them by means of the microscope. The fact that cases of tuberculous disease of the genital organs have been in the past and are still often overlooked is being more and more clearly recognized and I do not think that J. Whitridge Williams goes too far when he says that probably only about one-quarter of the actual number of such cases have been rightly diagnosed. In seven tables quoted by Williams the frequency of genital tuberculosis at autopsies on phthisical women varied from 1 to 8½ per cent. It is a well known fact that even at operation the real nature of the process may easily go unrecognized. In 137 laparotomies performed at the Johns Hopkins Hospital in only two cases was the tuberculous character of the process recognized at the time of operation and yet on microscopical examination

\*Read before the Cuyahoga County Medical Society, February 1st, 1900.



Williams was able to demonstrate five additional instances of tuberculous processes. Thus, it will be easily seen how fallacious the macroscopical appearance may be in such cases and the rule may certainly be laid down that until tuberculosis has been definitely excluded by microscopical examination, it is never justifiable to make an absolute diagnosis of gonorrhœal infection. Only from the microscope can we obtain absolute certainty. The history in such cases is often vague and, as has been said, even at operation the macroscopical appearances may be deceptive. In the present paper I wish to report somewhat in detail two examples of a tuberculous condition of the genital organs in which the diagnosis of a suppurative gonorrhœal process would undoubtedly have been recorded had not a careful microscopical examination of the tissues in each case given undoubted proof of the tuberculous condition.

#### CLINICAL AND PATHOLOGICAL REPORT OF CASES.

Case I. A. McM., age 18, white, single, occupation housework. Admitted to Charity Hospital Feb. 8, 1897, with the following history: Her mother and two sisters died of tuberculosis. The patient herself had never had any serious sickness. The menses first appeared when she was 14 years of age. They were irregular for about six months, but after this time they occurred regularly. The patient states that in November, 1896, she failed to menstruate and there has been practically no menstrual flow since that time. With the stopping of the menstruation she began to complain most all of the time of a dull, aching pain in the lower part of the abdomen which was increased upon the slightest exertion. She noticed a leucorrhœal discharge one month after the cessation of the menstrual flow. The abdominal pain finally became so severe that she was unable to attend to her work and she was obliged to go to bed. No positive history of a gonorrhœal infection could be established.

Physical examination of the chest revealed nothing abnormal. The examination of the catheterized specimen of urine did not show any defective condition of the kidneys.

Feb. 10, 1897. Upon examination made under anaesthesia the following notes were recorded. The outlet is somewhat relaxed, the cervix is in the axis of the vagina, and is soft, the external os is somewhat dilated. The fundus is in slight ante flexion and is somewhat enlarged. On the left side a fluctuating mass can be made out which fills up the broad ligament on this side and

also extends up toward the umbilicus. This mass is firmly attached to the pelvic wall. On the right side a smaller mass can be made out.

On Feb. 16, 1897, an abdominal section was performed for double chronic salpingitis with abscess of both ovaries. Incision was made in the median line through moderately thick abdominal walls. The omentum was found to be adherent to the parietal peritoneum and also to the anterior surface of the uterus. Several coils of intestines were found adherent to one another, to the posterior wall of the uterus and to the broad ligament. The adherent surfaces of the intestines were separated and the tube and ovary on the left side which were adherent to each other and to the broad ligament were peeled away from the broad ligament and the pelvic wall. During the manipulation an abscess cavity ruptured, allowing about 60 cc. of pus to escape. The abscess sac was removed in pieces and after passing interrupted sutures through the broad ligament on this side the greater part of the sac was removed. This left a large raw surface in the left broad ligament over which iodoform powder was dusted. The right tube and ovary were also found densely adherent to the posterior surface of the uterus. The tube and ovary on this side were delivered, the pedicle was transfixed, ligated and incised, and the stump was then cauterized. The abdominal cavity was washed out with three litres of sterilized salt solution and gauze was introduced into the abdominal cavity for drainage. A portion of the omentum, which was adherent to the anterior abdominal wall, was separated and the bleeding surface of the omentum ligated. The epiploicae at the point at which the intestines were adherent were very much thickened. The patient made an uneventful recovery. The temperature for a week before the operation varied between 99 deg. and 102 deg. F.; by the end of the second week after the operation it had gradually fallen to normal. The patient gained 36 pounds during the next six months and is now perfectly well and able to do hard work.

#### MACROSCOPICAL DESCRIPTION.

*R. Adnexa.* A shaggy mass the size of a small billiard ball, presenting remnants of numerous firm adhesions over its whole surface. The anatomy of the parts is much disturbed and it is almost impossible to identify the tube. No body resembling the ovary can be made out. Several small translucent cysts are found

\*From the Pathological Laboratory of the Western Reserve University.

near the uterine extremity of the tube. At the opposite pole of the specimen is seen a granular, light greenish-yellow, irregular surface, about two square inches in area, of irregular shape. This represents the wall of an abscess which was ruptured at the operation. Below this is a small fimbriated tuft which may be an œdematous fimbriated extremity of a tube. A probe can be passed a short distance into a crypt in the middle of this tuft. Small tufts of omental fat are adherent to the specimen.

The tube is enormously thickened. The only part which can be positively identified is the uterine end. This measures 1.5 by 1.5 cm. in diameter. The lumen is much distorted and has assumed a crescentic shape. The walls of the tube are tough and are enormously thickened. On section, when the lumen of the tube was laid open, the tufted body spoken of above is found to be the fimbriated extremity. The lumen is patulous the whole length of the tube. The mucosa is deeply disintegrated.

*Diagnosis.* Ovarian abscess, chronic, endo- myo and perisalpingitis.

*L. Adnexa.* An irregularly pear-shaped, cystic mass 5.5x4x3.5 cm. Neither tube nor ovary can be definitely demonstrated. The largest part of the mass is made up of tense, thin-walled translucent non-communicating cysts, which on section exude clear hyaline contents resembling the vitreous of the eye-ball. (The contents were probably fluid when the specimen was in situ and had been partly coagulated by the formalin used in the preservation of the specimen.) At the upper border of the specimen is a structure resembling, to judge from its exterior, the tube. When incised, however, it is found to be formed from a reduplication of the wall of a collapsed cyst. Remnants of firm adhesions are numerous. On opening the largest of the cyst and clearing away the hyaloid contents, the wall of the cyst is found to be very thin, and, on its anterior aspect, pearly white and glistening. No trace of any papillary bodies can be found.

*Diagnosis.* Probably multilocular cystoma ovarii glandulare.

#### MICROSCOPICAL EXAMINATION.

*Right tube at uterine end.* No proper peritoneal coat can be determined. The exterior of the tube is rough and irregular; it is composed of musculo-fibrous tissue, infiltrated with round cells. Several large vessels are seen, distended with blood. No tubercles are seen.



The *muscular coats* are irregularly thickened. They contain an undue amount of fibrous tissue, and are deeply infiltrated with round cells. At the attachment of the meso-salpinx, numerous tubercles are seen.

*Mucosa.* Much disintegrated. Only a trace remains of the plicæ and of the thin normal columnar-celled covering. The mucosa has been replaced by a tissue resembling granulation tissue in which are numerous tubercles. The granulation tissue is composed of round and epithelioid and spindle cells. Surrounding the tubercles are dense infiltrates of round cells. The giant cells show aggregations of vesicular ovoid nuclei arranged eccentrically around a cheesy finely granular centre.

Tubercle bacilli were demonstrated in moderate numbers. Most of those found in the giant cells were near their periphery. Some were found in the immediate neighborhood of the giant cells.

*Diagnosis.* Tuberculosis of tube, with myo- and peri-salpingitis together with tubercular infiltration of the meso-salpinx.

*Section of ampullae of right Fallopian tube.* The specimen was prepared to show the destruction of the mucosa. This was apparent macroscopically. Exactly the same pathological processes are seen as have been described in the former section. The destruction of the papillae and of the columnar epithelium has not advanced so far as in the former section, although it is very pronounced.

*Diagnosis.* Same as foregoing section of tube.

*Section of wall of ovarian abscess.* R. The part of the wall next to the abscess presents the same pathological processes as have been described when speaking of the tube, giant cells, tubercles and round-celled infiltration, etc. Tubercle bacilli were found. The part of the wall farthest from the abscess cavity is composed of fibrous muscular tissue rich in curling vessels. It strongly resembles the stroma at the hilum of the ovary. It is infiltrated with round cells. It is not possible to demonstrate absolutely, even with the microscope, that it is ovarian tissue.

*Diagnosis.* Tubercular ovarian tissue.

On March 3, 1897, as we had found a tuberculous condition of the tubes and ovaries I decided to curette the uterus. A small amount of debris was obtained. This examination of the scrapings gave the following results:

*Superficial epithelium.* Apparently multiple layers of irregularly shaped columnar epithelium. A very few cilia can be seen at some of the entrances to the gland ducts. Here and there an irregular single layer of columnar cells constitutes the superficial epithelium.

*Utricular glands.* Rather fewer in number than normal. Course somewhat indirect. The lumina vary considerably in size but are mostly round or oval. Some are ectatic. Some few instances of invaginated tubules are met with.

*Glandular epithelium.* Multiple layers (generally double layers) of columnar cells. Cilia are seen in many of the lumina. In some of the lumina single layers of cells are seen. In the ectatic lumina the cells are of the low columnar type.

The stroma in general is composed of small round and ovoid cells. Numerous small round cells, mostly of the mononuclear type are scattered through it. At irregular intervals are seen typical tubercles containing giant cells.

The tubercles themselves are surrounded by a thin area of round-celled infiltration and some few round cells are seen in them. They are chiefly composed, however, of small polynuclear epithelioid cells. The giant cells are large and contain many nuclei. These nuclei are vesicular, with a few granules of varying size staining with the haematoxylin deeper than the rest of the nucleus. The nuclei as a rule are arranged peripherally in the giant cells. The centre of the giant cells is faintly granular and in some a very few tiny, translucent, refracting globules are seen. Some of these tubercles are situated close to almost normal gland tubules.

*Diagnosis.* Endometritis tuberculosa.

Case. II. Mrs. D., age 25, married, nullipara, occupation housework. Menses first appeared at 14 years of age, regular, lasting three to five days; flow at times profuse and generally without pain until the past year, since which time she has had a considerable amount of dysmenorrhœa. Leucorrhœa slight in amount. No history of any gonorrhœal infection. Patient has been complaining for the past six months of backache and a dull, aching pain in the lower abdomen, more marked on the left side. The family and personal history have no bearing on the case.

On examination of the pelvic organs the uterus was found inclined forwards and fixed in the pelvis. On the left side a dense, slightly fluctuating tubo-ovarian mass could be palpated.

The structures on the right side could not be definitely felt. Abdominal section was advised and performed July 27, 1896. An incision was made in the median line through moderately thick abdominal walls. The mass on the left side was found to be about the size of an orange and to consist of the tube and ovary, which was densely adherent to each other, to the broad ligament and the pelvic wall. They were enucleated after separating many adhesions. The pedicle was then transfixed, ligated and incised. The right tube and ovary were also found adherent. They were enucleated, transfixed, ligated and incised. The abdominal cavity was then thoroughly flushed with sterilized salt solution and sponged dry, and gauze drainage was introduced. The patient made a slow but satisfactory convalescence and is now well, is able to do her household work, and is free from any pelvic discomfort.

This case would undoubtedly have been classified by many as one due to a specific gonorrhœal infection. The microscopical examination, however, clearly proved its tubercular character.

\*MACROSCOPICAL EXAMINATION.

*L. Tubo-ovarian mass.* Irregular mass somewhat larger than a croquet ball. No traces of ovary, which is replaced by an abscess the size of a lemon, spheroidal in shape and filled with thick, light-colored pus. The wall of the abscess is about 7 mm. thick. Externally the surface of the abscess wall is shaggy with remnants of numerous broad adhesion bands, so that it has the appearance of having been in part shelled out of a bed. The inner surface of the abscess wall is shaggy and rugous, as if numerous stunted papillae were present. At one point a small, sharp spicule of lime salt is found.

The L. tube is remarkably straight in its course, 11 cm. in length and of even diameter throughout. The walls are thickened. The tube at the middle measures 1.5x1.2 cm. The abdominal end is patulous. The fimbriated extremity is not patulous. The fimbriae are bound down and puckered in by adhesions, which separate them into two masses. The ovarian fimbriae reach down toward the seat of the ovary (i. e. towards the abscess). Adhesions are numerous and mostly fine and small.

*Cyst.* Below the tube and between the layers of the mesosalpinx is a cyst which before rupture was of the size of a croquet ball. It was filled with clear, limpid, slightly yellowish (straw

\*From the Pathological Laboratory of the Western Reserve University.



colored) fluid. The cyst ruptured during extraction. The walls are thin and translucent. Externally the cyst wall is shaggy from remnants of adhesions which are moderately numerous and strong. Internally the wall is smooth, in places of a light bluish gray, in places whitish and mottled.

There is but one cyst cavity. No signs of daughter cysts. No papillary excrescences.

*Diagnosis.* Endo- myo- and peri-salpingitis adhesiva. Intraligament, cystoma ligament. lat. Abscess of ovary. Occlusions of abdominal end of tube. General adhesions.

*R. Ovary.* Small, normal in size, several large unruptured Graafian follicles seen near surface, also a recently ruptured follicle and one older ruptured follicle. Moderately firm consistence, yellowish gray color, some adhesions. Mesosalpinx, ovary and tube present numerous delicate "spider-web" adhesions.

*R. Tube.* Both ostia patulous, convoluted, normal in size. Near fimbriated extremity on upper surface is a small pediculated thin-walled translucent cyst, size of a 32 caliber bullet. Further towards the fimbriae is a small fimbriated pedunculated body, not previous (an accessory ostium).

The mesosalpinx is thin, delicate and translucent; the parovarium can be easily made out. Near the outer end of the parovarium under the peritoneum is a small subperitoneal cyst of the size of a split pea.

*Diagnosis.* Peri-oophoritis et peri-salpingitis adhesiva.

#### MICROSCOPICAL EXAMINATION.

*L. Tube.* Section taken from about the middle of course of tube.

No peritoneal coat demonstrable. The outer border is rough and shaggy. Here and there are seen remnants of fine small adhesions. The muscular coats are deeply infiltrated with round cells. These are especially numerous in the vessels and in the lymph spaces.

*The mucosa.* The papillae have lost their delicate papillary shape and have become agglutinated together in the center or near the center of what was formerly the lumen of the tube. The agglutination has gone on to complete loss of the epithelial covering at the ends of the papillae and they have grown and fused together. At about the central point of the agglutination is a large deposit of calcareous matter. (This prevents making a very thin section of the tube.) "False gland" lumina have been formed.

Immediately around the chalk deposit is a considerable amount of round-celled infiltration. Some of the tissues in the immediate neighborhood of the chalk are undergoing degenerative change of a necrotic nature. No giant cells are to be found.

The stroma of the papillae is infiltrated with leucocytes. The vessels contain very many leucocytes.

*The epithelium.* Apparently a single layer of medium columnar cells. Cilia (?) appear in places, but generally cannot be satisfactorily demonstrated. Comparatively little debris in the lumen.

*Diagnosis.* Peri- myo- endo- salpingitis.

Section of septum between abscess and cyst. This section presents three parts, (a) wall of abscess, (b) wall of cyst, and (c) intermediate tissue.

(a). *The abscess wall* presents an irregular margin. It is made up of granular tissue, rich in round cells. There are many epithelioid cells of varying size whose nuclei take the haematoxylin stain less intensely than do the round cells. Vessels are numerous and have thin walls. Strings of fusiform cells are also seen and also a few scattered fusiform cells. In places the fusiform cells are forming the walls of new vessels. In some spots in this granulation tissue are small areas of necrosis. These are indicated by diffuse haematoxylin staining. Giant cells with very finely granular centres and with nuclei arranged eccentrically are also found in considerable numbers. No areas of cheesy change can be demonstrated. Many sections were stained by appropriate methods to demonstrate tubercle bacilli, but none were found. Large single discrete cocci were found in scrapings from the abscess wall.

(b) The intermediate septal tissue is made up of a finely fibrillated hyaline structure, containing comparatively few nuclei, many thin-walled blood vessels and many round cells. It is a fibrous tissue, infiltrated with inflammatory products. There is no sharp line between (a) on the one hand and (b) and (c) on the other.

(c) No trace of an epithelium is found on free margin. It is composed of large epithelioid cells, round cells, fibro-blasts, and blood vessels.

*Diagnosis.* Septal wall between abscess and cyst.

# DISCUSSION ON DR. ROBB'S PAPER.

Dr. Robb in closing:

In answer to Dr. Stuart's question I would say that the pus from both cases by the coverslip examination and by the tubes that were inoculated gave negative results.

I will endeavor to answer the further questions as follows:

*Etiology.* How does the tubercle bacilli gain access to the genital tract? Three modes are possible.

(1). The bacilli come from areas of tuberculosis already existing elsewhere in the body.

(2). They can come from outside by direct infection or after being present in the body and having come to the surface they may be carried directly from the outside to other parts of the body.

If an area of tuberculosis exists in the body the infection is carried to the genital tract most commonly by the blood. In puerperal women suffering from miliary tuberculosis, the disease has been found to be most marked at the site of the placenta. We can well understand that localized tuberculosis in the genitals may be analogous to the tuberculous processes found in the bones.

In the latter class of cases the prevailing opinion is that the infection comes through the blood current.

In the case of bone tuberculosis it is not necessary to have a large or in fact any known tuberculous focus elsewhere in the body; and here again we have an analogy with some cases of genital tuberculosis.

Salleron, a surgeon in the French army quoted by Williams, reports fifty-one cases of genital tuberculosis in the male; in fifty of which no signs of tuberculosis could be found elsewhere.

It is almost impossible to believe that all these cases were due to a direct infection from the outside, and we are therefore left to suppose that it must have taken place through the blood current.

Primary bone tuberculosis would seem to show that the tubercle bacilli may be conveyed in the blood current to various parts of the body without causing any demonstrable lesion at the point of their entrance into the body.

There seems to be no reason why the reasoning just applied to genital tuberculosis in the male should not be true also for the female.

The occurrence of tuberculosis near the abdominal end of the tube if the peritoneum is not affected does not necessarily disprove the argument that the disease might have come through the blood



current. If, however, the peritoneum is already involved in all probability either the tuberculous process has extended from the tubes to the peritoneum or vice versa, the latter being probably more frequently true.

Pinner found that minute solid bodies like powdered cinnabar if introduced into the peritoneal cavity of rabbits and dogs often passed through the tubes and uterus, and were finally discharged through the vagina. This result was probably due to the current produced by the cilia of the tubal and of the uterine epithelium.

It is clear then that the bacilli could pass to the genital organs in the same way.

An interesting fact is noted by Weigert. He maintains that the eruption of tubercles is often most plentiful in the pelvic cavity, the bacilli having followed the law of gravity and having fallen to the lowest part of the pelvic peritoneum where they are in the best possible condition to be taken up by the current of the tube.

Infection may come from the other organs by perforation caused by tuberculous ulcers and the consequent formation of a fistulous communication between the diseased structure and some portion of the genital tract. Perhaps the most common cases resulting from this manner of infection are found in recto-vaginal fistulae.

The relative frequency of genito-urinary tuberculosis in men as compared with women is in the proportion of three to one. This is due to the difference in the anatomical arrangement of the urinary and sexual organs in the two sexes.

The fact that the urethra in men is the channel through which both the urinary and sexual secretions must pass, whereas, in the woman the urethra belongs simply to the urinary system gives far greater opportunity for the infection in the case of the male.

(3). Tubercle bacilli can gain access to the vagina from the outer world in various ways, by the use of unclean instruments, unclean linen, and in a multitude of other ways, but more especially by coitus with the male infected with some form of genito-urinary tuberculosis.

I have said that tubercle bacilli are undoubtedly introduced into the vagina in this way. I do not think that any one can dispute this statement, but this does not prove at all that genital tuberculosis must result from their introduction.

Before, however, I bring forward the arguments on this subject I will digress for a few moments and say that in thousands of instances tubercle bacilli, although admitted to the cavities of the body, do not give rise to a definite tuberculous process.

In an article which I cannot recall at this moment there is a record of the examination of secretions of thirty individuals, doctors, nurses and others who were in attendance on tuberculous patients; in a very large percentage the presence of tubercle bacilli was demonstrated.

Now it was an undoubted fact that a tuberculous process was not set up in all these persons.

With the great number of tubercle bacilli that are around everywhere it is possible that the most of us absorb not a few, but fortunately the majority of us possess sufficient resistance so that that tubercle bacilli finds himself like the seed sown by the wayside and "the leucocytes come and devour them up."

The possibility that infection might take place through coitus was first suggested by Cohnheim. At first sight there seems to be no possible objection to such a theory. There is no doubt that a great many cases of genito urinary tuberculosis in the male have passed unrecognized, and besides this, it must be remembered that a tuberculous man might introduce bacilli into the vagina without presenting any recognizable signs of tuberculosis of his genitals.

Jani writing in Virchow's Archives says that he has found tubercle bacilli in the testes and prostate glands of tuberculous patients without there being any other signs which would have led him to expect the existence of tuberculosis.

If bacilli were introduced in this manner it is highly probable that owing to the resistant nature of the structures in the vagina and cervix that infection would not take place unless the bacilli reached the uterus.

Again, it is possible that superficial miliary tubercles forming in the endometrium of the uterus would be cast out with exfoliation of the superficial layers of the mucosa which takes place at every menstrual period.

We should expect, therefore, that the lesions would be serious only if the bacilli have penetrated as far as the fallopian tubes where they can multiply without molestation, or if some of the bacilli remained in the uterus despite the exfoliation, to which we

have referred. If this is true we have a very plausible explanation of the fact that the tubes are much more frequently affected than the uterus, even in primary cases.

The argument of Cornil and others deduced from this fact of the rarity of tuberculosis in the vagina and the cervix that infection by coitus rarely occurs is therefore not of much value.

Tuberculosis of the mouth and of the pharynx are very rare even in cases of pulmonary tuberculosis.

Numerous cases of suspected infection by coitus have been recorded, but most of them are not conclusive.

Derville in eight cases of genital tuberculosis in women found in all of the husbands hard masses in the epididymis which he considered of tuberculous origin.

It is unfortunate that Derville could not demonstrate that the affection in the men was undoubtedly tuberculous, as otherwise his proofs would have been irresistible.

The injection into the vagina of rabbits of tuberculous material does not by any means always give rise to a tuberculous infection. Indeed, it is rather uncertain if it ever does.

Whitridge Williams therefore concludes that it has never been satisfactorily proven that genital tuberculosis occurs as the result of infection by coitus. He does not, however, deny that it might occur. I think that our present knowledge does not warrant any more positive conclusions.

The symptoms are very obscure, and in cases of secondary infection of the genital tract are often quite overshadowed by those of the primary disease.

Some cases have been reported in which hemorrhage and suppuration led the patient to consult her physician were tuberculous, although at first the diagnosis of carcinoma was made in each case.

When the uterus is affected the leucorrhœa is generally very profuse, the discharge consisting of a caseous material mixed with the ordinary uterine secretion.

Some authors have laid great stress upon the occurrence of menstrual disturbances early in the disease, but no great value can be attached to these symptoms.

If the ovaries and tubes alone are diseased the symptoms may be those of a single salpingitis, and we may have every gradation between them and those of a pelvic abscess. It is impossible, however, to make a diagnosis before operation, and we may



be uncertain until the abdomen is opened whether we are dealing with a case of adherent tubes and ovaries, or with a pus tube. Amenorrhoea belongs to the low general condition due to phthisis and is not peculiar to genital tuberculosis.

In two of the cases reported by Williams in which the disease was found to have been very far advanced no menstrual disturbance whatever had been noticed by the patient.

Tuberculosis, so long as it is limited to the tubes and ovaries, does not necessarily give rise to any characteristic symptoms, and accordingly it is impossible in the majority of cases to make a diagnosis. If, however, there are signs of pulmonary or peritoneal tuberculosis we should always suspect genital tuberculosis when tumor masses can be recognized in the region of the ovaries and tubes.

Before the discovery of the tubercle bacillus the positive diagnosis of genital tuberculosis could not be made *intra vitam*. The difficulty varies according to the greater or less accessibility of the parts affected.

It is not hard to confound tuberculosis of the vulva and vagina with several affections, but in doubtful cases the microscope will clear the matter up.

Miliary tubercles of the vagina resemble the granulations of a granular vaginitis. The latter, however, is so frequently associated with pregnancy or with gonorrhoea that the history will often be of service.

Papillar and ulcerated syphilides will disappear under anti-syphilitic treatment.

Herpetic eruptions around the vulva generally occur as small cysts and appear about the menstrual period and soon disappear again. Tuberculous ulcers may be mistaken for hard or soft chancres, but the history if taken into account together with the character of the ulceration should prevent any mistake. Here again the microscope will help us.

Carcinomatous ulcers can be distinguished from tuberculous ulcerations by microscopical examination.

If no tubercle bacilli can be found in the secretions the uterus should be curetted and the scrapings hardened in alcohol. Sections can afterward be made for microscopical examination.

It is practically impossible to diagnose tuberculosis of the tubes and ovaries by bi-manual palpation alone. The thickened condition of the uterine end of the tube, a sign to which Hegar

attached so much importance, can occur in cases of pyosalpinx without tuberculosis.

Small myomata could also be easily mistaken for tuberculous masses. The association, however, of a tumor in the tube with the ill defined anomalous mass in the abdominal cavity should rouse suspicion of abdominal tuberculosis. In other words, if we diagnose tuberculous peritonitis we must suspect every mass connected with the tubes and ovaries to be tuberculous.

Under the head of cases of unsuspected genital tuberculosis Williams mentions five cases in which on macroscopical examination the diagnosis of ordinary catarrhal or purulent salpingitis had been made.

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## A RESUME OF THE DIFFERENT METHODS OF TREATING HYDROCELE.

BY NICOLA CERRI, M. D., (ROME, ITALY.)

By the name hydrocele we understand a collection of serous fluid in the tunica vaginalis testis, acute or chronic, the result of a past inflammation and due to a disproportion between the transudation and absorption of the serous surfaces, an acute inflammation of the tunica we designate as a vaginalitis.

The treatment of hydrocele may be either palliative or radical. The first comprehends external application or simple evacuation of the fluid. The second, on the contrary, includes evacuation with irritation of the serous surface, and incision, which may or may not be followed by partial or total removal of the tunica vaginalis.

PALLIATIVE TREATMENT.—(a) *External applications.* In the past, different substances, such as collodion, adhesive plaster, elastic pressure, etc., were used in the hope that the pressure exerted by this means on the scrotum would indirectly produce a re-absorption of the fluid. But all these methods were found to be more or less unreliable. (b) *Simple evacuation.* This is done by using a trochar. After having rendered the scrotum aseptic, it is necessary to know the position of the testicle, because in case of inversion or misplacement of this organ, one may, in introducing the trochar, injure it. It is well to remember that the testicle is generally situated below posteriorly, and near the median raphe. The surgeon, having ascertained the position of the organ, grasps the tumor below between the thumb and fingers of

the left hand in order to fix the tumor and distend it. Then with a trochar (preferably a small one), in the right hand, with a sudden movement the instrument is plunged through the scrotum into the tunica vaginalis. When he withdraws the obturator, the contents of the sac will escape through the cannula. The cannula should be withdrawn with the left hand, after the evacuation of the fluid. The puncture should be hermetically sealed by a little piece of gauze and iodoform collodion. But these cases treated in this manner usually relapse. Cures have been accomplished by this method in those rare cases of congenital hydrocele, without communication with the peritoneal cavity.

**RADICAL TREATMENT.**—(a) *Evacuation followed by irritation of the tunica vaginalis.* Different methods have been resorted to, with the intention of producing on the internal surface of the tunica an adhesive inflammation, so as to cause a union of the two serous surfaces. This can be accomplished by the injection of irritating substances, after having evacuated the fluid. Some have used, for this purpose, the fluid itself, which they have drawn off; others, alcohol, carbolic acid (5 per cent. solution), or better still Augol's solution.

Professor Deume used the pure tincture of iodine, but these injections are painful, and sometimes they might cause alarming symptoms.

Some have used solutions of corrosive sublimate, the sulphate of zinc, the chloride of zinc, and others have injected hot and cold water.

Professor Durante, after having evacuated the fluid, replaced again the obturator in the canal and with the front of it, he scratches with considerable force the endothelial surface, which being mechanically irritated, an acute traumatic vaginalitis is produced, and thus we obtain a union or adhesion of the serous surfaces. Precautions should be taken to prevent infection following the operation, which can occur from an organ near by, namely, the penis, if the patient should have gonorrhoea.

Some years ago, Dr. Juathrocicchi very ingeniously thought of a good method for curing hydrocele which could succeed without forcing the patient to remain in bed, and which is at the same time very simple. After having evacuated the fluid by a trochar he introduces through the cannula a catgut thread twenty centimeters in length. This thread by mechanical irritation which it produces is capable of exciting an adhesive inflammation of the



serous surfaces, a "vaginalitis obliterans," and in a few days it becomes absorbed. But many authors have observed that the thread can be absorbed too quickly, and at the same time the irritation will not be great enough to produce a union of the two surfaces. Some have advised placing the thread in some irritating liquid, usually the perchloride of iron. The results are extraordinary, recovery is certain, and the patient can attend to his business, which is of considerable importance, especially for a laboring man. At the worst, if the inflammatory reaction is very severe it is only necessary to remain in bed for one or two days.

(b) *When the tunica vaginalis is very thick we would recommend the classical operation of Volkman or Von Bergman.*

For the treatment of simple hydrocele Dr. Cimicelli has proposed electrolysis, which has given good results. If we have to do with a congenital hernia complicating hydrocele, we would advise operation according to the method of Bassini.

108 Scovill Avenue, Cleveland, O.

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## REPORT OF A CASE OF SEPTICAEMIA, WITH METASTATIC ABSCESES AND CICATRICIAL CONTRACTION RETARDING LABOR.

BY CHARLES L. WEBSTER, M. D., CLEVELAND, O.

I was called in March, 1895, to attend Mrs. R., who was supposed to be suffering from consumption. Found her with a high fever and severe cough. She had been operated on at her home some time previous for lacerated perineum and cervix. Blood poisoning and metastatic abscess followed the operation. A large abscess formed on the left arm and one in the right groin. A little later the right leg began to swell just above the knee and when I saw her was nearly twice its normal size. She had been kicked by a cow fourteen years before. Following this injury a hard tumor gradually formed in the same location as the present swelling, but had not caused her any pain or inconvenience till lately.

I diagnosed a metastatic abscess in the lung and one in the leg, involving a previous bone tumor but probably not the shaft of the bone. Sinuses had formed through which pieces of bone were discharged at this time or soon after. Whether there was an abscess in the lung or not, the cough soon subsided but the bone abscess persisted. I took her to a man who is considered

the best surgeon in this country, who pronounced it bone sarcoma and advised amputation. I did not agree with him, and a few days later made a large incision over the tumor. Found just what I expected. The shaft of the bone was not affected. After chiseling off the exostosis and thoroughly scraping out the abscess cavity the wound filled rapidly with healthy granulations. Patient left the hospital in ten days and the leg was soon as good as the other.

In March, 1897, I was called to confine this same patient. After waiting twelve hours with very little prospect of the head engaging, decided to perform version. Was surprised to find that I could not get my hand into the vagina and was compelled to make two lateral incisions before I could proceed. Version was easily performed, but it took so long to deliver the head that it was impossible to resuscitate the child. If I had realized at the time that the cicatricial tissue in the cervix was causing the tedious labor I might also have incised the cervix and perhaps saved the child. The womb was so well dilated that except for the resistance of the cicatricial tissue in the cervix and perineum there would have been no difficulty in delivering the child. I at once cut out the cicatrix between the two lateral incisions and repaired the lacerated perineum, which had been attempted so long before, and with such disastrous results. This case illustrates some of the dangers as well as the remote consequences which may follow infection even in what are called minor gynecological operations.

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## **Abstracts and Extracts.**

### **THE NEURO-MUSCULAR ELEMENTS IN HIP-JOINT DISEASE.**

The Orthopedic Section of the New York Academy of Medicine, with Dr. Judson as chairman, recently discussed this common and very interesting subject.

Dr. N. M. Shaffer read a paper of which the following is an abstract:

If, as was generally conceded, the origin of hip-joint disease was in the epiphysis, a great center of growth and development supplied from the central, spinal and great sympathetic nervous centers, it would be readily seen that the presence of a foreign

body like the bacillus of tuberculosis in such an osteitic focus would cause serious nerve irritation.

The following neuro-muscular elements had been recognized and described: 1. Involuntary tonic muscular contraction. 2. Muscular atrophy. 3. Reduced faradic reaction. 4. Increased muscular excitability. Together they presented a clinical picture of an irritative peripheral nerve lesion and gave expression to a distinct reflex spinal condition. They were absent from a joint suffering, a simple injury, and from primary tuberculous degeneration of synovial membrane, which was comparatively simple in structure and nerve supply.

#### REFLEX MUSCULAR SPASM.

This sign had been noticed early in his practice by the reader of the paper, who had spoken of it in 1872 as a "reflex muscular spasm," the first time, so far as he was aware, that the term had been applied to the sign. The occurrence and character of the spasm were unmodified by opium or chloral, but it was annulled by ether or chloroform. It produced joint deformity and sometimes simulated ankylosis. Clinically it was of the utmost importance. Its presence was the first sign of the disease and its absence the surest warrant for the suspension of treatment. It was involuntary, tonic, tetanoid.

When passive motion reached a certain point, at which the intra-articular pressure excited nerve irritation, the muscles involved, hitherto quiet, suddenly contracted and resisted further motion. When that point was reached the alert joint sense almost talked to the observer. When convalescence approached and actual immobilization was no longer required the motion permitted by the apparatus used should be to the inner side of the point indicated by the spasm. Protection, however, should be maintained until the joint was free from reflex muscular spasm when the patient might safely be restored to a gradually increasing use of the weakened limb freed from its diseased joint. Cases illustrating the ill effects of not heeding this indication were related.

#### MUSCULAR ATROPHY.

In this sign of joint disease we were dealing with something more than the effect of disuse. It was far from being functional atrophy. Although an early, important and expressive sign, its significance was impaired at a later stage by the incidental effects of mechanical treatment which included rest and compression. This was to be borne in mind when the patient and his friends



were apt to think that the atrophy was entirely the result of maintaining too long the restraints of treatment.

Before applying electricity to the muscles involved the reader of the paper had surmised that reduced faradic reaction would be found. It was seen to be uniformly present in all of the atrophied muscles which were subjected to electrical test. In 1892 increased muscular excitability was shown by Dr. E. G. Brackett to be a fourth constant neuro-muscular element in hip joint disease, readily demonstrated early in the disease by the exaggerated patellar tendon reflex.

#### DISCUSSION OF REFLEX MUSCULAR SPASM

Dr. V. P. Gibney said that the reflex muscular spasm was valuable as an aid to correct diagnosis and of great assistance in determining the time when to give up protective treatment. It was difficult, however, in every case to recognize the final disappearance of this sign. The best test of a joint which had been long under treatment was the use of the limb for one or two weeks, even in spite of the spasm. If, after free use, close observation revealed an increase in motion the brace might be discarded, but if the range of motion had decreased, with perhaps a little more spasm, mechanical treatment should be resumed.

Dr. T. H. Myers said that the presence of synovial tenderness, or peri-articular pain, or stiffening of the affected joint, or neighboring joints, from prolonged immobilization might easily make difficult a clear recognition of the resistance to motion made by reflex spasm. It was better to err by attributing the resistance arising from these causes to reflex action than to make the mistake of not recognizing the presence of the tetanoid spasm. He related the recent history of a boy, who had been entirely free from all other signs, in whose case a positive, afterwards confirmed, diagnosis was made on the presence of slight reflex spasm near the limit of passive motion, and the history of a girl seen ten years ago who on superficial examination appeared to have been cured of acute hip disease. There was wide motion and no lameness. When, however, the thigh was flexed, and at the same time prevented from outward rotation and abduction, a slight reflex muscular protection was found at the limit of motion. As the parents objected to a further continuance of treatment the patient was dismissed "improved but not cured," to suffer a return of the acute symptoms a few months later.

Dr. G. R. Elliott thought that there was no hard and fast rule as to the discontinuance of treatment. Instruments should be used readily, permitting whatever increase of motion the symptoms warranted, to be discarded only when free movements for a considerable time were followed by no bad results.

Dr. W. R. Townsend recognized the nervous complications of joint disease and the practical value of reflex contraction as a clinical sign in disease of the hip joint.

Dr. H. L. Taylor acquiesced in the views presented, first, that reflex contraction was the earliest sign of hip disease, and second, that so long as it persisted treatment of the joint could not be safely discontinued, views generally, if not universally, accepted by American orthopaedic surgeons.

Dr. R. Whitman agreed with the now commonly accepted view of the diagnostic significance of the reflex muscular spasm of hip disease. He thought that muscular spasm in convalescence corresponded to the acuteness rather than the area of the intra-articular process and called for absolute restriction of motion in addition to protection, for the completion of resolution.

Dr. A. B. Judson said that John Hunter had noticed the peculiar action of the muscles in joint disease. He said (1786): "Stiffness of the joint depends on the involuntary contraction of the muscles. . . . I think this arises from sympathy, or a consciousness of the parts being unable to answer to the action of the muscles, and it comes nearest to human reason of anything in the body." The words "on guard" (H. G. Davis), and the graphic expression, "*vigilance musculaire*" (Verneuil), had been applied to the watchful attitude of the muscles in joint disease. Though present in other diseased joints reflex muscular action was seen best in the hip because, being a ball and socket, it depends more than any other kind of joint on its muscular system for both motion and stability. For this reason reflex muscular contraction was of great importance in the diagnosis of the earliest stage of hip disease when the lameness is inconstant, the atrophy equivocal and the pain referred to the knee. It was of no less importance as a sign of convalescence.

Dr. Myers said that ten years ago he had observed five patients affected with hip disease each of whom received a number of injections of tuberculin. He had made 20 or 30 tests of the muscular spasm in each case, and it was found that in the reactions

caused by the injections the spasms became more alert as the temperature arose, and diminished with the fall of the temperature.

Dr. Elliott said that nerve irritation at the site of the disease was reflected through the cord and gave rise to the spasm of the muscle.

Dr. W. Truslow said that the fact that slowly applied and progressively increased mechanical traction completely and quickly overcame the muscular action suggested, the tetanoid quality of the spasm.

Dr. F. Peterson thought that the word tonic expressed the condition of the muscles in hip disease and that the word tetanoid was not applicable. Apart from a reference to the reflex theory, the tonic spasm might be explained on the theory of an irritation of the cells of the nerves connected with the joint in the same way that the tonic spasm in muscular rheumatism, so-called, of the sterno-cleido-mastoid muscles is supposed to come from irritation due to some poison affecting the nerves. Hyper- and hypo-tonia of the muscles might be here considered. In locomotor ataxia hypo-tonia is referred to destruction of nerve fibres and the muscles in joint disease might by some irritation be kept in a condition of settled hyper-tonia.

Dr. Taylor thought that tetanoid had a certain suggestiveness, but he preferred the word tonic or some one of the other terms which were in general use.

Dr. Elliott thought that tetanoid better than tonic defined the character of the spasm, which was sometimes clonic.

Dr. Myers thought it probable that a similar spasm might attended non-tubercular lesions of the bones and joints, such as partial fracture or complete fracture without a displacement. He thought he had seen spasm very like that of hip disease in such cases.

Dr. Taylor said that there was nothing especially diagnostic of the tuberculous condition in tetanoid or reflex spasm, which might appear different at different stages, or in different cases, of tuberculosis disease, as it did in given cases of such different affections as tuberculosis, osteo-myelitis, rheumatism and synovitis, the spasm depending on the location and grade of the irritation rather than on its pathological origin. It would not be often found in synovitis.

Dr. Whitman said that reflex spasm as an evidence of the irritation and sensitiveness of a joint was not found in synovitis



and was not restricted to tuberculosis disease, although that disease was its most common cause.

#### DISCUSSION OF MUSCULAR ATROPHY.

Dr. E. D. Fisher said that these signs of hip disease could be referred to the reflex action of the spinal cord. But using the term reflex did not go far as an explanation. The cerebrum is not involved. Serious implication of the spinal cord or the nerve supply of the muscles was out of the question; but in malnutrition of the spinal cord he thought we had possibly an explanation. On this theory the whole reflex arc would be involved. Beginning with a sensory disturbance the irritation is carried to the cord through the posterior roots and then to the anterior horn where it caused spinal irritation or exhaustion, if it might be called that, and atrophy. A parallel might be found in disease of the fifth nerve, with reflex irritation of the seventh, causing spasm of the face in which removal of the cause of irritation in the nerve or the ganglion relieved not only the pain but the spasm.

The term reflex conveyed little or no explanation unless it became part of some coherent plan the result of reasoning and fortified by post-mortem examination. He recalled a case of ankylosis of the knee and atrophy the result of an injury at the age of 7 and followed by an autopsy at the age of 41. There was marked atrophy of the anterior horn in the segment corresponding to the knee and in the cerebral convolution controlling that part of the body. It was common to find atrophy thus localized after the loss of a member in early life.

Altogether, the presence of these elements in hip joint disease confirmed the theory of a trophic center in the spinal cord. Wasting was common at the onset of joint disease, in which the consecutive atrophy was always more rapid than in an injury to a large nerve. Recovery was also more rapid than in poliomyelitis in which the lesion might be a destructive one.

Dr. Peterson said that an explanation by reference to the passage of an irritation to the spinal cord and its reflection along the trophic nerves to the muscles was scarcely a probable one, because irritation of trophic nerves generally gave rise, as it did in any sort of nerve, to an excess of function.

In joint atrophy there was wasting away of muscles from wasting away of trophic centers or destruction of trophic fibers. Faradic action was reduced in quantity but normal in quality. The manner of response to the faradic and galvanic currents was

normal though the muscle was wasted. The subject was interesting because of the absence of the reaction of degeneration. In the atrophies of progressive poliomyelitis, with actual degeneration of trophic centers there was profound reaction of degeneration. In only one other class of marked muscular atrophy was reaction of degeneration absent, the class of primary muscular dystrophies, not due to any nerve lesion, in which there was destruction of the muscular fibers, which wasted away one after the other, those left responding in a normal way. In very marked instances of this condition there was reaction to the faradic current as in joint atrophy. Joint atrophies might be explained in a similar way, without reference to the spinal cord, on the ground that, although many of the trophic fibers coming to the muscles which moved the joint would be connected with the joint, all of them were not, and when an inflammatory process in the joint destroyed trophic fibers and produced atrophy some of the muscular fibers were not destroyed and responded with absence of the reaction of degeneration as happened in progressive muscular dystrophy.

In rheumatism and sciatica and other painful affections there was increased muscular excitability, as shown in the knee-jerk. The response to the stroke of the tendon was, however, too rapid to allow of a trip to the spinal cord and back, and yet it was governed by spinal cord conditions. Neither this nor the other neurological conditions found in hip joint disease need be necessarily considered in connection with the spinal cord.

Dr. Elliott said that the novel and interesting dystrophy theory might explain the atrophies of monarticular rheumatism and rheumatoid arthritis, which were distinct from the joint atrophy under discussion.

Dr. Whitman said that, among other contributing factors, physiological disuse was the most important and constant cause of the atrophy of joint disease, which affected all the component parts of a limb, including the bone. It increased for a time more rapidly when the symptoms were relieved by fixation of the limb. It followed fixation of the limb in splints after fracture of a bone.

Dr. Gibney said that much of the atrophy following the use of apparatus for several years was caused not only by disuse, but also by constricting bandages and appliances.

Dr. Elliott said that joint atrophy was specific and in no way related to the disuse atrophy and to that which came from bandaging.

Dr. Townsend said that disuse, which was an obvious and controlling factor of the later atrophy, played a very unimportant part in the production of the early and characteristic atrophy of joint disease, which appeared in patients confined to the bed.

Dr. J. B. Bogart said that the joint atrophy of the neurologist arose from a nerve lesion, but the atrophy of orthopaedic practice had threefold origin in nerve implication, disuse and the restraint incident to treatment.

Dr. Taylor suggested over-work as a cause of the primary atrophy. When a muscle was exercised beyond a certain point or subjected to prolonged electrical excitement it atrophied and the continuous localized sensory irritation of joint disease might over-work the muscles in physiological sense through the motor centers in the cord.

Dr. Fisher said that the muscular atrophy caused by over-use could be referred to spinal cord atrophy, as was almost conclusively proved by the experiments of Hodge, who had recorded atrophy in the spinal cord cells of pigeons which had been flying for hours.

Dr. Taylor said that in cases of diseased hips of long standing there was an interference with the circulation and an extensive atrophy affecting even the bones, which doubtless had several factors, including retarded growth of the parts affected, in addition to the early joint atrophy. Similar effects were to be seen in the wake of infantile paralysis and fracture of the femoral neck in children and in certain congenital malformations.

Dr. Judson said that in many cases of serious disability of a lower extremity a large part of the asymmetry was due to hypertrophy of the unaffected limb from over-use.

Dr. Peterson said that the results of joint atrophy could not be confounded with those of disuse. In a shoulder joint, immobilized by acute arthritis, there was rapid atrophy of the muscles, which was absent from a shoulder joint immobilized in any other way. In an injury of the brain, as in apoplexy, there was disuse but no atrophy of the muscles at all. In fracture of the femoral neck in a child one side did not grow as fast as the other. In infantile cerebral hemiplegia one side of the body did not grow as fast as the other, not from atrophy but from retardation of



growth on the paralyzed side. In any serious injury of an extremity retardation of growth came from disuse, or from interference with nutrition from disuse.

Dr. Shaffer said that at one time he had seen several patients with hysterical imitation of hip joint disease under treatment for months by the long hip splint, adhesive plaster and bandaging. In some of these cases there was muscular resistance but no atrophy. After true hip joint disease the muscular atrophy might never wholly disappear but the limb would do its work well. If considerable motion returned to the joint as the result of treatment the patient would walk without a limp and in ankylosis in a good position a most useful limb would result.

In his earlier studies he had found no reference to the spasm of hip joint disease in the then limited works on orthopaedic surgery, but in Charcot's lectures he had found light on the subject and he had for many years steadfastly called attention to this interesting phase of chronic tuberculosis joint disease and, inasmuch as spasm and atrophy were not observed in chronic synovitis of the knee and ankle, he had proposed that hip joint disease, like Pott's disease, was an osteitis and not a synovitis.

In his paper he had tried to indicate when apparatus might be discarded in hip joint disease. This decision could not be rightly made until the tetanoid spasm was duly appreciated. It was not difficult to recognize it, once its peculiar characteristics were understood. He thought that the word tetanoid would sooner or later be generally considered to be applicable or that some other word, broader than tonic and more comprehensive than reflex, would be applied by neurological students, who had here a subject well worthy their investigation to the end that the profession might know the real value of the neuro-muscular elements in hip joint disease and recognize that they had a distinct pathological origin.

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## Editorial.

### THE AMBULANCE AS SHE IS RUN IN CLEVELAND.

The ambulance service of our city is in the hands of the undertakers. Not for burial, more's the pity, but looking toward the burial of those who are so unfortunate as to need ambulance service, and a source of danger to some who otherwise would not. They are private enterprises, these ambulances, practically unregulated by the city, the hospitals, the doctors, or apparently by

anybody who understands the proper methods of ambulance service.

Of course there are in existence ordinances upon the subject. The only regulations that we know of are comprised in sections 176 to 179 inclusive, of the Revised Ordinances. Section 176 sets forth that "whoever shall provide and properly maintain acceptably to the director of police, a suitable ambulance or other vehicle for transportation of sick and disabled persons, shall when summoned" have the same rights in the streets as the fire department, namely, that when the ambulance runs everybody shall get out of the way—if he can. Section 177 requires that the ambulance be supplied with a gong, rung when the vehicle is in motion, and with lights at night. Section 178 requires a bond of a thousand dollars "to hold the city harmless against damage sustained by persons or property by rapid or reckless driving." Section 179 says that the city shall pay for the transportation of such sick or disabled persons as are unable to pay for themselves, upon recommendation of the director of police.

Of the fifteen or more ambulances operated in this city there is not one that is customarily accompanied on its runs by a surgeon. If there is one there is not more than one accompanied by a driver or attendant who has had a previous training in rendering first aid to the injured. The undertaker hires almost anybody for an ambulance driver, perhaps his main recommendation being that he has been a cabman or an expressman. After awhile he may pick up a few points in first aid. The second man with the ambulance is likely to be whoever is nearest at hand about the stable at the time the call comes in. The principal object of the ambulance men is to "get there" first and get the body. They must drive about as fast as the horse can go in order to be first on the ground and claim the victim, or be able to take him away from other drivers who arrived simultaneously. It's a poor ambulance man who doesn't get either the patient or some part of the patient out of an accident. Disgraceful scenes of wrangling over bodies, alive or dead, have more than once been enacted among the ambulance drivers in this city. First aid to the injured is unthought of in most cases. There has been many an injured patient loaded into an ambulance and transported, with never a properly applied tourniquet, or a temporary splint, or an anodyne, or an antiseptic, or a stimulant, or artificial respira-



tion, or anything else that might have been to his advantage upon the spot or *en route* to the hospital. And the trip to the house or the hospital—there is no hurry about that. The hurry is over when once the patient is secured in the ambulance. Quite a leisurely pace is now sufficient, and if the patient dies on the way—well, there is surely a profitable job for the undertaker. In some cases the choice of hospitals is left to the driver of the ambulance or his master, the undertaker, and patients have been taken to this or that hospital because there was a bonus to be had for so doing, or because there was an understanding that in case of death the undertaker whose ambulance brought the patient held a sort of mortgage that entitled him to bury or otherwise dispose of the body. In short, the ambulances in this city are run by and in the interests of the undertakers rather than in the interests of suffering humanity. They jeopardize more lives at every run than they save by their precipitation. Frequently there is more time wasted waiting for an ambulance than would suffice to send the patient to the hospital or his home by an express wagon or other passing vehicle, with or without first aid at the hands of the nearest doctor.

The ambulance service in this city is very far from what it should be; and it is improbable that it will be properly carried on until the ambulances are maintained and served in connection with the hospitals. Aside from the funerals which it secures, an ambulance cannot be a very profitable investment for an undertaker. With fifteen or more competitors it is out of the question for him to hire properly trained attendants. It is questionable whether it would be expedient to have a system of ambulances as a branch of the Police Department, in connection with the Health Office, or under the Department of Charities and Correction. But in the present state of public disposition toward taxpaying such a project would be impracticable. The only feasible plan is to have an ambulance maintained in connection with each hospital, so that one of the house doctors would be ever at hand to accompany the ambulance on its runs and take proper care of patients, the ambulance always carrying the necessary dressings and appliances for first aid in emergencies.

The ambulance should not be expected to be a source of profit. It should class with the hospital as a necessary humanitarian institution sustained at an expense. It should be looked upon from the hospital point of view. As long as it is viewed

from the undertakers' viewpoint it will be little more useful than the deadwagon, while it is a great deal more dangerous.

KELLEY.

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## BETTER ENVIRONMENTS FOR THE POORER CLASSES.

In an article in the December issue of the *GAZETTE* attention was called to the fact that a movement was on foot to secure better environments for a large portion of the people, particularly for the children of our city, and for the prevention of those influences which create the slum with all its baneful influences. To further this movement the following gentlemen met and organized a committee:

For the Council of the Teachers' Physical Education Society—Dr. L. K. Baker, Mr. L. H. Jones, Mr. E. L. Harris, Mr. H. C. Muckley.

For the Young Men's Christian Association—Mr. G. K. Shurtleff, Dr. W. H. Kinnicutt.

Social Settlements—Mr. G. A. Bellamy, Mr. Star Cadwalader.

Central Friendly Inn—Mr. W. E. Wayte.

Medical Journalism—Dr. S. W. Kelley.

Municipal Association—Mr. M. A. Fanning.

Dr. Baker, Supervisor of School Hygiene, was appointed chairman, and deserves great credit for his efforts in this work. Members of the committee raised over two hundred dollars and secured the services of Mr. J. A. Riis, the great slum fighter of New York. On the evening of February 19th Association Hall was filled with a representative audience. In his address Mr. Riis referred to some of the social and municipal reforms in New York with which his name is so intimately associated. Mr. Riis exhibited most vividly the effect upon health, physical and moral, of tenement houses overcrowding, dirty streets, poor school accommodations and the like. The work of the Board of Health and of Colonel Waring in combatting these influences was frequently alluded to. The sympathy of the audience was at once secured. As the speaker proceeded, his hearers became positively enthusiastic.

Mr. Riis' suggestion that Cleveland should secure the Tenement House Exhibit, to be given in Chicago and later in Paris,

should be realized, for, as we have pointed out, the symptoms of an epidemic of tenement house construction is upon us.

On Tuesday Mr. Riis spoke at the College, and during the afternoon to a cultured and most enthusiastic audience at the opening of Alta House. In the evening he talked to a large audience from the Italian neighborhood, for whom the house has been built.

The visit of Mr. Riis to Cleveland is a really important and significant event, and we would do well to profit by it. If Cleveland is to avoid the unpleasant experiences of New York and other great centers of population, it behooves her to realize that the time for action is at hand. The average citizen does not usually trouble himself with problems of hygiene, physical development, sociology until the evil is so flagrant as to be unendurable, and he is spurred to action by others. But physicians should be awake upon these topics and give their knowledge and their influence for the betterment of the people. At present there is needed a strong public sentiment against crowding of inhabitants and in favor of public playgrounds, gymnasias and baths in the congested districts.

Ere long there will be needed legislation upon these subjects—legislation sufficiently specific, for instance, to regulate the amount of air space to each person in a tenement, the ventilation, the lighting; and authority to destroy some dens of filth and disease now disgracing our city.

KELLEY.

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#### THE CLEVELAND MEDICAL LIBRARY ASSOCIATION RECEPTION AND SMOKER.

On Saturday evening, February 3rd, the Cleveland Medical Library Association gave an informal reception and smoker to the medical profession of Cleveland at the Library Building, 586 Prospect street. The committee in charge of the arrangements was composed of Dr. A. R. Baker, Dr. H. H. Baxter and Dr. William Lincoln. The opinion of all is that the committee did their work well.

After a number of the physicians had arrived and spent some time in chat and smoking, Dr. A. R. Baker called the meeting to order. He made a few introductory remarks and then introduced Rev. Dr. E. E. Baker, who spoke in a most complimentary way. Mr. A. W. Cogswell sang several solos which were heartily ap-



preciated. He was accompanied on the piano by Mr. Sontum.

Dr. Frank E. Bunts followed with a short address and read the following paper, which deals in a pleasing, satirical manner with the present method of discussion in some medical societies:

AN UP-TO-DATE REPORT OF PROCEEDINGS OF AN UP-TO-DATE MEDICAL SOCIETY.

*First Surgeon:* I have to bring before the members of this society a report of an extremely interesting case of rupture of the liver. The patient was accidentally kicked over a fence by a mule and fell with his right side striking on a nigger head. No symptoms developed for twenty-four hours, when the family, becoming alarmed at the absence of symptoms, I was called in to see the case and at once diagnosed a rupture of the liver. The signs were somewhat obscure, but an operation made some thirty-six hours subsequent proved the correctness of my observations. The liver and portal vein were carefully sutured, the abdominal wound closed by four rows of sutures—catgut, silk, silk-worm gut and silver wire respectively—and the patient made an uneventful recovery, the stitches being removed on the seventh day, and the patient returned to his occupation as mule driver two days later, or nine days from date of operation. In conclusion, I would say that the chief points of interest in this case are the accuracy of the diagnosis, as well as of the facts in the case, and the most excellent results following a most hazardous and desperate operation.

*Chairman:* The most interesting paper of Surgeon — is now open for discussion.

*Occulist:*<sup>1</sup> I am sure we are very much indebted to Surgeon — for his most valuable contribution to surgical knowledge, and the case reminds me of a rupture of an eyeball in a well-known man about town, following an attempt to watch all the ballet girls at once. In this case I made a careful examination with the ophthalmoscope, finding marked evidence of blepharospasm posterior synechiae and choked disc and external strabismus. The treatment consisted of a prompt removal of the eye. The cure was prompt and uneventful, and up to this date he has not attempted again to attend a ballet performance. In conclusion, I again wish to congratulate the author and the society upon his paper.

*Gynecologist:* The subject under discussion is somewhat out of my line of work, but it is a very brilliant result and re-

minds me of a case of endometritis fungoidis complicating a Bartholinian cyst in a patient 96 years of age. In this case I removed the uterus and appendages per vagina after excision of the cyst. She made an uneventful recovery, and has since married and feels as young as she did seventy years ago. I thank the doctor for the opportunity which his paper has given me to present this case.

*Rhinologist.* I cannot allow this opportunity to pass without referring to a case which this valuable report of a rupture of the liver has brought to mind. Some years ago, Mary G. snuffed a bean up her nose. A careful inquiry at the time failed to reveal the bean, but yesterday, or two years from date of first observation, there appeared an unmistakable bean sprout extending at the anterior nares. I at once diagnosed a sprouting bean and removed it, under cocaine. No untoward effect was produced, the patient making an uneventful recovery. The interesting feature in the case was that the patient came from Boston and had probably been addicted to the bean habit for many years. I congratulate the doctor upon his very able paper.

*Neurologist.* Rupture of the liver must call to mind of all of us that from such sudden jars we may obtain ruptures of the cerebral sinuses, or hemorrhage into the spinal canal. In a similar case to that related by the doctor, motor paralysis was present from the moment of receipt of shock incident to receipt of check for an outlawed bill. I made the diagnosis without any difficulty and offered to relieve the patient of the exciting cause. This he refused, and his paralysis was recovered from in time to take in the races the next day. Again I wish to congratulate the doctor upon his very elaborate and painstaking paper.

*Second Surgeon.* I can but endorse everything that the author has said and appreciate fully the value of the paper. I wish to take exceptions, however, to the means of diagnosis and to say that from the symptoms related there could not possibly have been a rupture of the liver—nor could he, in my estimation, have sewn up the portal vein without seriously interfering with the functions of the liver and bringing on an attack of the piles. In all the cases of this kind in which I have operated I have made it a point at the same time to dissect out very carefully the pile bearing area. In conclusion, Mr. Chairman, I would say that I hope no one will think from my remarks that I differ in any es-

amentals from the practice of my distinguished confrere.

*Orthopedist.* During my connection with the Hospital for Cripples I noticed very often and have the records of 150 cases which show the difference in appreciation of pain in different children. In some of the cases of kyphosis a plaster bandage was well tolerated, notwithstanding the formation of decubital sores, extending down to and laying open the spine,—while in others bitter complaint was made by the patients and it was necessary to remove the plaster and apply it according to an original method devised by me. The resemblance between these cases and that related in the paper this evening is very marked, and I appreciate the value of this addition to medical knowledge as confirmatory of my own experience at the Hospital for Cripples.

*Chairman.* As there is no further discussion upon this paper I would say that we are all very much pleased by the elaborate and carefully prepared discussion which it has called forth,—and I will ask Surgeon ——— to close the discussion.

*Surgeon* ———. The field of surgery has been so fully covered that I feel it impossible for me to add anything to that which has been already said.

The foregoing paper was appreciated by all, and Dr. Bunts was congratulated on the faithfulness of his reproduction. Refreshments for the inner man completed the program, which ended about 11 p. m.

LAUDER.

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### IS THE LAW COMPLIED WITH?

It may not be generally known that among those diseases which are required, by law, to be reported there is one the possible results of which to human happiness is beyond calculation. The disease referred to is ophthalmia neonatorum. The ravages of this affection are so disastrous that it very properly became a subject for legislation, so that, at the present time, most of the European governments and the laws of several of the States in this country require the reporting of all cases of ophthalmia neonatorum to the constituted authorities. The States which have passed such a law are as follows: Maine, New York, Rhode Island, Minnesota, Ohio, Maryland, Connecticut, Missouri, Iowa, New Jersey, Pennsylvania and South Carolina.

Although such a law has been passed it is yet necessary that the laity should be better informed as to the dangers of a disease which so many regard as simply a cold in the baby's eyes. To



this end it would be well if all charitable organizations having the care of children, or of women likely to become mothers, should make it a point to impress upon them the necessity of keeping a careful watch of the baby's eyes. For this purpose cards containing something like the following should be on hand for distribution: "When the baby's eyes begin to look red and to run matter, take it at once to the doctor. It is very dangerous, and if not treated properly one or both eyes may be lost." (Used in the Sheffield, England, General Infirmary.)

Not all cases of ophthalmia neonatorum are due to the gonococcus. Any of the pathological vaginal secretions can set up a purulent inflammation of the conjunctiva, so that there need not be any false modesty on that score.

It is estimated on reliable statistics that at least 25 per cent. of the blindness that exists in the civilized world today is the result of ophthalmia neonatorum. If we calculate the cost of the keep of a single person as ascertained by the best regulated institutions which look after the blind, as, at least, one hundred and thirty-two dollars per year, and that each able bodied person could earn one dollar per day, we shall determine that the financial loss to the commonwealth of the United States alone, as the results of this disease, exceeds the sum of seven and one-half million dollars annually. With this *fact* to think of, is it any wonder that legislation was enacted with a view to lessening the ravages of the disease? The medical profession generally must certainly have some knowledge of the lamentable possibilities of this disease and should exert their every effort to check it. But what about the midwife? There is no doubt but that in their hands very many of these cases have their origin. Let every physician be on the alert and see to it that, as these cases come under his notice, whether directly or from the hands of a midwife, the law is complied with, and there is no doubt but that the result will be highly salutary both with regards to a decrease of the disease and in showing to the midwives that they have more to deal with than they had anticipated.

LAUDER.

## Periscope.

*Oxidizing Ferment of the Liver.* By MARTIN JACOBY (*Virchow's Archiv*, 1899, 235).—The oxidizing ferment of the liver resists to some extent the action of alcohol; small quantities of chloroform increase its activity, but in large quantities of this reagent the activity of the ferment, as tested by the action of the minced organ on salicylaldehyde, is destroyed. The addition of small quantities of alkali furthers, but of larger quantities (beyond 0.3 per cent. of sodium hydroxid) destroys, its activity. Very small quantities of hydrochloric acid do not lessen its action, but when the concentration reaches 0.1 per cent., only traces of salicylaldehyde are oxidized. A temperature of 75 degrees C. does not completely destroy the ferment, but one of 100 degrees C. does so. Various substances were subjected to the action of the minced liver in order to see which of them were oxidized; no oxidizing action was observed on sodium thiosulphate, sodium acetate, stearic, or palmitic acids. Sugar is not formed from these fatty acids. Uric acid also is not destroyed by calves' liver; but with dogs' liver there is some indication of oxidizing action. In diabetes, the oxidizing action of the liver is normal. The glycolic ferment is not identical with the oxidizing ferment; the former is destroyed at the comparatively low temperature of 58 degrees C., and is differently affected by chemical reagents as compared with the latter. Glycolysis appears to be a function of the cells. The liver is liable to oxidize small quantities of arabinose. The change of glycogen into grape sugar does not appear to be due to the oxidizing ferment. Oxidations in the body fall under three main headings: First, those which are not fermentative; second, those brought about by cells; and, third, those produced by oxidoses in the body—juices.

*Thyroid Gland.* By ERNST ROOS (*Zeit. Physiol. Chem.*, 1899, 40).—A large number of estimations of the iodine in the thyroids of different animals are given. As a rule, this element is more abundant in the vegetable feeders; but is sometimes absent even among these.

Renewed researches confirm the author's previous statements that the main active substance is iodothyryn. No actual observations are recorded on myxoedema, but other diseased conditions were observed, and experiments made on metabolism.

*Physiology of the Iodin—Containing Substance of the Thyroid Gland.* By F. BLUM (*Pflueger's Archiv*, 1899, 70).—Fresh experiments are recorded to confirm the author's previous conclusions that the thyroid is an excretory organ removing poisonous substances from the blood, and that the iodine found there originates in this way. Iodothyron is regarded as an artificial product; the iodine of the thyroid is in combination with proteid; the proteid is not fully saturated with iodine, and the amount of iodine per cent. varies considerably. The proteid itself belongs to the toxalbumins. Ostwald's thyreoglobulin, obtained by half-saturation with ammonium sulphate, is not a single substance. The thyroid gland is not to be regarded as an organ pouring a useful internal secretion into the circulation; the lymph leaving it, and the lymphatic glands in the vicinity do not contain iodine; and the blood and central nervous system in healthy animals are also free from iodine. Removal of the thyroid is followed by disease and death, because the organ which removes poisonous substances from the blood can no longer protect the animal. It is the central nervous system which principally suffers, and by Nissl's method great changes (chromatolysis) can be demonstrated in the ganglion cells. The thyroid, therefore, appears to be the great protective organ to the central nervous system. The poisonous substances are destroyed by oxidation, and this appears to be assisted by combination with the iodine.

*Excretion of Uric Acid.* By SCHREIBER and WALDVOGEL (*Chem. Centr.*, 1899, 849).—Two students fasted for three days at the beginning of the research, they passed daily 0.477 and 0.718 gramme of uric acid respectively, and on the third day 0.197 and 0.205 gramme. The amount of uric acid does not run parallel to the total nitrogen or to the acidity of the urine; it does not disappear with vegetable diet. Animal food causes a rise in the xanthine bases, but not in the uric acid excreted, whilst salicylic acid causes a rise in both.

*Autodigestion of the Pancreas.* By S. PFOERRINGER (*Virchow's Archiv*, 1899, 126).—Previous authors have called attention to the possibility of self-digestion being a cause of pancreatic cysts and necroses. Chiari (*Zeit. Heilk.*, 1896, 17) in particular, has directed attention to the fact that the pancreas is often found partially digested after death, and he considers that this may begin in the last hours of life. The present investigations



confirm Chiari's views; it contains records of a hundred autopsies; the pancreas was examined microscopically, and evidences of digestive necrosis was found in forty-five, and this was very marked in eleven cases. The conditions of the patient (age, disease, etc.) appear to be as varied where such necrosis is found as in those cases where it is not found.

*Passage into the Urin of Chloroform Administered by Inhalation.* By DIOSCORIDE VITALI (*L'Orosi*, 1899, 145).—From the results of tests made on the urin of four patients before and after the administration of chloroform, the conclusion is drawn that chloroform does not pass into the urin. The presence in the urin of organic chlorin compounds produced from the chloroform could not be detected.

*Influence of the Kind and Amount of Nutriment on Metabolism.* By EDWARD PFLUEGER (*Pflueger's Archiv*, 1899, 425).—The object of the paper is to show that proteid is the great source of energy; it increases metabolism and raises the resistance and power of the animal; it does so by increasing the substance of the living cells, sometimes doubling their weight. Fat and carbohydrate have no such power. Fat never arises from proteid in the animal body. Man cannot take all his nutriment in the form of proteid, simply because of the limitation which exists in his digesting power.

SPENZER.

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## New Books.

RECOLLECTIONS OF A REBEL SURGEON (and other sketches) OR, IN THE DOCTOR'S SAPPY DAYS. By F. E. Daniel, M. D. Illustrated. 1899. Von Boeckmann, Schutze & Co., Austin, Texas.

This is one of the reddest books we ever saw. It's a redder red than the cover of the *Texas Medical Journal*, and that's saying a good deal. Was it Bill Nye who published a green book and then a red one, and then cherished a fiery ambition to publish a still redder volume? If such an ardent hope burns in the bosom of Dr. Daniels, he will never see it realized, for this one is as red as can be—and it is prettily ornamented with gilt, and a lone star—than which, in the eyes of a Texan, nothing is so ornamental.

The inside of the book is just as bright and attractive as the outside.

In the introduction the author introduces the "Fat fee-losopher," or "The jolly old Doctor," who is supposed to tell the

stories which have been surreptitiously recorded by a phonograph and are here reproduced. He then indulges in a short disquisition on the southern dialect before allowing the old doctor to settle down to the story telling. (By the way, "yankee" is spelled with a small y all through the book. Perhaps this is a "southernism" too.) And the stories? Well, we are pretty sure they are true, for we heard some of them told for the truth around Texas campfires twenty odd years ago—certain proof of veracity. But they have improved—either by time or by working through the old doctor's "retroscope" or the phonograph. Others are new to the reader and doubtless came out of the author's private stock. They are of actual occurrences—some sad, some pathetic, but mostly humorous. A few of them relate somewhat to the professional duties of the army surgeon, and they all give many a glimpse of life in the south "endurin' of the war." S. W. K.

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**PULMONARY TUBERCULOSIS. ITS MODERN PROPHYLAXIS AND THE TREATMENT IN SPECIAL INSTITUTIONS AND AT HOME.** ALVARENGA PRIZE ESSAY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA FOR THE YEAR 1898, REVISED AND ENLARGED. By S. A. Knopf, M. D., (Paris and Bellevue, N. Y.) Physician to the Lung Department of the New York Throat and Nose Hospital; Former Assistant Physician to Prof. Dettweiler, Falkenstein Sanatorium, Germany; Vice-President of the Pennsylvania Society for the Prevention of Tuberculosis; Fellow of the American Academy of Medicine; Laureate of the Academy of Medicine of Paris, etc. With descriptions and illustrations of the most important Sanatoria of Europe, the United States, and Canada. Octavo. Price net \$3. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia, Pa.

A well written, exhaustive and practical work upon tuberculosis, and an acceptable and welcome addition to the scant literature which we already have upon this subject. The book is beautifully and profusely illustrated and adds greatly to the understanding of the subject matter. Although interesting data are given relative to the history of tuberculosis, and some space is also devoted to the proofs of the curability of the disease and also to its communicability, the greatest interest of the work attaches to the chapters upon public prophylaxis, the preventive treatment, and the care and method of treatment practiced in the sanatoria. The hospitals for consumptives and the sanatoria throughout this country and Europe are described and illustrated, giving much valuable information. Altogether the work is the most complete that we have seen upon this most important subject. G. S. S.

OPERATIVE SURGERY. By Joseph T. Bryant, M. D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospitals, etc. Vol. I. General Principles, Anæsthetics, Antiseptics, Control of Hemorrhage, Treatment of Operation, Wounds, Ligatures of Arteries, Operation on Veins, Capillaries, Nervous System, Tendons, Ligaments, Fasciæ, Muscles, Bursæ and Bones, Amputations, Deformities and Plastic Surgery. This volume contains 749 illustrations, 50 of which are colored. D. Appleton & Co., New York. Third edition.

This volume, the general scope of which is indicated in the table of contents, is written by a practicing surgeon and eminent teacher, and in this third edition, as the author informs us in the preface, much new and original matter has been introduced to bring the work up to the present advanced standard of surgical technique. We have gone over the work with much interest and profit. In the chapter upon the general considerations, we notice that the author in speaking of the time of a surgical operation, lays particular stress upon the fact that the time of operation should be agreed upon between the patient and surgeon and the engagement promptly kept. *A surgeon cannot afford to be lacking in punctuality on those occasions.* Patients often look upon the operation with a dread akin to that of the culprit awaiting punishment, and they also fix the time when the operation will be completed as the moment in which they start upon the road to recovery. A needless delay may often prove disastrous to the surgeon, arousing suspicion and doubts, and with the patient's loss of courage the surgeon sometimes loses the patient.

Under the head of anesthetics, we should have been pleased to see the author give more prominent attention to the administration of oxygen with chloroform and ether, as we believe that this mixture tends to diminish the danger of the anesthetic, as well as lessen the disagreeable symptoms such as vomiting, delirium, and other dangers associated with the administration of a general anesthetic.

The illustrations are very numerous. In one respect an interesting departure is made in presenting the instruments for a given operation in half-tone groups. In this way, all the instruments essential for a given operation may be seen at a glance, and so aid very materially in selecting those required for the operation. The illustrations in the chapter upon ligatures of the arteries are especially complete and clear.



Perhaps as extensive and as valuable a chapter as any is that upon the operations on the nervous system. The author usually gives only the practical and well-tested methods, nevertheless, in the chapter on operations upon the veins, capillaries, etc., some space is given to illustrations and the text describing the methods of direct and mediate transfusion. As a matter of fact, these methods are now very rarely, if ever, used. The safe transfusion of saline solution and its positive effects has rendered these dangerous methods all but obsolete.

This work when completed will be one of the most practical and useful books for both practitioner and student that has recently appeared upon this important subject. PARKER.

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**LECTURES UPON THE PRINCIPLES OF SURGERY.** Delivered at the University of Michigan. By Charles B. Nancrede, A. M., M. D., LL. D., Professor of Clinical Surgery, etc. With an Appendix Containing a Resume of the Principal Views Held Concerning Inflammation. By Wm. A. Spitzley, A. B., M. D., Senior Assistant in New York University of Michigan. Illustrated. W. B. Saunders, 925 Walnut St., Philadelphia, Pa. Price \$2.50.

This volume of something less than 400 pages is not intended to represent the views and theories of the many writers upon surgical principles, but represents the author's views upon the principles of surgery, and the author's especial methods of applying these principles to practice. In this respect we may regard the work as a monograph. It is most interesting to note how the great principles of bacteriology and pathology have been wrought over and applied to the principles and practice of surgery by the author. Although the author gives the up-to-date principles of bacteriology, yet he couches his thought in such familiar language that it does not require a laboratory specialist to follow him, and general practitioners, especially those who never enjoyed the advantages of laboratory instruction, could scarcely find a better book in which to study bacteriologic principles as applied to surgical practice than in this work of the author.

The chapters upon surgical fevers are worthy of especial mention. He divides surgical fevers into sapremia, septicemia and pyemia. "Sapremia," he says, "should theoretically be applied only to the constitutional effects produced by the absorption of the chemical products of saphrophyticgerms. It is probably true, however, that at times the toxins manufactured by the pyo-

genic germs are taken up in sapremia, adding to the systemic poisoning, although the germs themselves, of course, do not gain access to the circulation." Septicemia is due to the access of micro-organisms into the circulation. "Pyemia," he tells us, "is a misnomer, the liquefied thrombi having been mistaken for pus collections occupying the lumen of the vessels. Pyemia is a disease resulting from the lodgment of septic or infected emboli but are in turn the cause of septic or infective thrombo arteritis." In these comprehensive definitions we gain a distinct knowledge of these conditions and the pathological conditions which cause them. Throughout the work we find the same clearness and directness in nearly all of the chapters. The treatment suggested is founded upon approved surgical principles and evinces a careful and conservative surgical technique. The author has retained the class-room colloquial style which adds to the interest of the reader.

The print is very clear, and the pages are very solid. The author has not repeated familiar illustrations, and the few that he has introduced into the text are original and illustrate some particular point in the author's methods or views upon a particular subject.

PARKER.

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## Society Proceedings.

CUYAHOGA COUNTY MEDICAL SOCIETY, FEB. 1,  
1900.

May L. Bassett, Medical Reporter.

The regular monthly meeting of the Cuyahoga County Medical Society was held on Thursday evening, Feb. 1st, at the Cleveland Medical Library. The meeting was opened with Dr. A. R. Baker, President pro tem, in the chair, who presided until the entrance of Dr. H. W. Rogers, one of the Vice-Presidents. The minutes of the last meeting were read and approved. The Treasurer gave a report which was referred to an auditing committee, who reported favorably, and the Treasurer's report was accepted. After the transaction of some miscellaneous business, the regular program was called.

Dr. B. F. Milliken read a paper on Iritis due to dental irritation.

Discussion of Dr. Milliken's paper.

*Dr. Baker:* The subject of mydriasis as the result of dental irritation is a very interesting one. My attention was especially called to it some fifteen or twenty years ago. A young lady, in the family where I was boarding at the time, had one pupil which was dilated widely and the other of the normal size. There was no great discomfort of the eye, though there was some photophobia.

I watched the case for a year or two, but was unable to find a cause for the dilatation. One day the young lady developed a toothache, and I noticed that during the time of the pain in the tooth, the pupil became the natural size again. A few weeks later during another attack of toothache, I noted the return of the pupil to the normal size until the attack subsided, when the pupil dilated again. Putting these observations together, I insisted that the diseased tooth was the cause of the eye trouble. I went with her to her dentist to have the tooth removed which had been aching, but as he refused, I was finally obliged to take her to another dentist to have it pulled. After its removal, both pupils resumed their normal size and gave no further trouble.

I am aware that this case does not throw any light upon the etiology of Dr. Milliken's most interesting case, but nevertheless presents one of the peculiar reflex disturbances of the eye we may have as the result of dental irritation.

*Dr. Tuckerman:* The farriers of the Eastern States have noticed that blindness in horses comes from the irritation of a certain tooth, and they pull it out. What basis they have for their belief I do not know, and I have never investigated the question. They call it the "wolf-tooth." They say it relieves the blindness if pulled.

*Dr. Corlett:* The paper and remarks which have been made remind me of the young lady, who, in detailing an account of her brother's illness, who had mumps, remarked that it had gone to the knee. The subject of reflex irritation is an interesting one. Of late we have, as Dr. Milliken says, come to look upon some of these irritations as the result of microbic changes.

Dr. Milliken and I at one time made some observations upon a few cases which came under this heading, one in particular—that of lopus erythematosus on the face—was found to be dependent on eye strain, and was reported, with two others, before the American Dermatological Association, as reflex dermatoses. The opinion expressed by members present was that although the



relationship seemed to be clinically well established, yet it was but a supposition, as we had no means of knowing positively. So observations of this sort are of value as tending to throw light on a subject which, at best, is but little known.

Personally, I believe we have reflex disturbances, and until something more definite is shown to the contrary, I shall look upon reflex disturbances as potent etiological factors of various diseased conditions.

*Dr. Hanson:* There is one peculiarity of these reflex disturbances, and that is that they nearly all occur in females. They hardly ever occur in males.

A CLINICAL AND PATHOLOGICAL REPORT OF TWO CASES OF GENITAL TUBERCULOSIS.

Dr. Hunter Robb presented a paper with the foregoing title.

Dr. Robb's paper with his closing remarks to the discussion appear in this issue of the GAZETTE.

Discussion of Dr. Robb's paper.

*Dr. Lower:* This paper of Dr. Robb's is of very great interest to me. I have seen recently four cases of tuberculosis of the Fallopian tubes, two of these cases being under the care of Dr. Crile, one under Dr. Bunts and one of my own. I do not know whether these cases are more frequent of late, or whether what we now diagnose as tuberculosis was considered some other infection. I think specific infection has been too generously applied to all inflammatory conditions of the tubes and ovaries. I would like to know how Dr. Robb diagnoses tubercular trouble of the appendages and what the probable source of infection is. Is it from the uterus? In only one of these cases were the scrapings of the uterus taken for examination. In the others abscesses were found. In all cases tubercles were found on the tubes and in several cases on the fundus. Very marked adhesions were present. Most of the cases were in very young women. In one case but one side was involved at first, but the other side became involved later and it became necessary to remove the other tube. At the time of operation it was thought that the other side was not involved. I am very glad that the subject is being investigated, and that such an able man as Dr. Robb has begun the work. I am sure we will learn more in regard to it soon.

*Dr. Hanson:* In speaking of tubercular infections, the old theory, of course, was that inhalation or breathing was the ordi-

nary mode of infection. I have seen a great deal lately on the question of the stomach as a probable medium of infection. I think we all know that the mediastinal glands are usually infected before the bronchial glands and lung tissue become involved. I am thoroughly convinced that many of us have tubercular disease that is latent, but still that we have it, are carrying with us those germs of infection ready to rouse up if circumstances become favorable. Now, as in these cases reported by Dr. Robb, the tubercle bacilli may have been latent but did not originate the disease directly, but become apparent only after the infective inflammations of gonorrhoea or other septic changes had begun.

*Dr. Stuart:* I have been very much interested in these cases of Dr. Robb's and would like to ask about the microscopic examinations. In the first case mentioned was the pus examined, and in the second case was there pus removed, and if so, was it examined?

*Dr. Corlett:* I am not able to discuss the very interesting report given by Dr. Robb. I would like, however, to say something on the effects of the gonococcus invasion.

Naegorath's gloomy dictum is familiar to you all. We know, too, that the gonococcus has been found in almost every organ of the body. It is only by microscopic and cultural tests, however, that one can form a positive diagnosis as to their presence. It seems to me these reports show that other agencies doubtless contribute to swell the lists which fell under Naegorath's ban. I have often remarked that a specific urethritis cannot, as a rule, be cured short of six or seven weeks, and that is about the period when the disease terminates spontaneously. There is a growing tendency to look upon the gonococcus as short lived, and, it may well be that many affections which have heretofore been regarded as due to gonococci are, in reality, the result of tubercular infection, and not of gonorrhoeic origin.

## Notes and Comments.

**Dr. Joseph F. Hobson** has been appointed surgical and medical supervisor of the insurance department of the Brotherhood of Railway Trainmen. The operations of this brotherhood extend from Maine to California and also embraces Canada. The head office has recently been established in Cleveland.

**Dr. A. P. Sculley** is house surgeon at St. Alexis Hospital.

**Dr. C. J. Herrick, Sr.,** has returned to the city, his health improved.

**Dr. Charles B. Parker** has returned to the city after an absence of a few weeks in Chicago and Milwaukee.

**Dr. Charles G. Foote** took charge of Dr. Parker's work during his absence.

**Dr. W. H. Leet,** of Conneaut, attended the Cleveland Medical Society meeting on February 23d.

**Dr. B. L. Millikin** was confined to his house the latter half of February because of an attack of la grippe.

**Dr. I. Friedmann,** of 465 St. Clair street, was married to Miss Jennie Newman, of New York, on March 11th.

**Dr. Manley Simons,** United States Navy, has been ordered to New Orleans, on duty at the Naval Recruiting Station there.

**Dr. Hunter Robb** read a paper before the Wayne County Medical Society of Detroit, on March 8th, on "The Results of Modern Aseptic Surgical Technique as Demonstrated by a Series of 114 Consecutive, Unselected, Abdominal Sections, without a Death, with Clinical and Pathological Reports." Dr. Robb was the guest of the society after the meeting.

**The Report has been Circulated** that the New Orleans Polyclinic has been suspended on account of smallpox in New Orleans. This statement is absolutely false. The Polyclinic has had a continuous course since November 20, and will continue until May 12. The smallpox situation in New Orleans has at no time justified any apprehension on the part of students attending the Polyclinic or on the part of those who might wish to do so.

ISADORE DYER, M. D.,  
Secretary New Orleans Polyclinic.

February 24, 1900.



**New Books to be Found in the Cleveland Medical Library.**

Dr. Allen's gift: Heisler—Text-Book of Embryology, 1899; Thoma—Text-Book of General Pathology, and Path. Anat., Vol. I, 1896; Habershon—On Diseases of the Abdomen, Stomach and Alimentary Canal (etc.); Hare—Medical Complications and Sequelae of Typhoid Fever, 1899; Gibson—Diseases of the Heart and Aorta, 1898; Tyson—Practice of Medicine, 1898; Reese—Text-Book of Medical Jurisprudence and Toxicology, 1898; Nancrede—Lectures upon the Principles of Surgery, 1898; Raymond & Janet—Neroses et Idees fixes, 1898; Janet, Pierre—L'Automatisme Psychologique, etc., 1899. From Dr. Hamann: Progressive Medicine, Dec., 1899; Gerrish—Text-Book of Anatomy by American Authors, 1899; Treves—Intestinal Obstruction. From Dr. C. B. Parker: Park—Surgery by American Authors, 1899. Purchased: Dunglison's Medical Dictionary, 1895; Treve's Applied Anatomy, 1892; Hutchinson & Rainy's Clinical Methods, 1897; Cheyne—Treatment of Wounds, Ulcers and Abscesses, 1895; Norris & Oliver—Text-Book of Ophthalmology, 1893; Taylor—Medical Jurisprudence; Gray's Anatomy in Colors, Descriptive and Surgical, 1897; Hall—Text-Book of Physiology, 1899; Attfield—Chemistry: General, Medical and Pharmaceutical, 1899; Bruce—Materia Medica and Therapeutics, 1899; Maisch—Organic Materia Medica, 1899; Crook—Mineral Waters of the United States and Their Therapeutic Uses, 1899; Cheyne & Burghard—Manual of Surgical Treatment, Vol. I, 1899; De Schweinitz—Toxic Amblyopias, 1896; Jewett—The Practice of Obstetrics by American Authors, 1899; Simon—Manual of Chemistry, etc., with plates, 1898; American System of Medicine, Loomis-Thompson, 4 vols., 1897-8; Park—Bacteriology in Medicine and Surgery, 1899; Tuttle—Diseases of Children, 1899; Hollopeter—Hay Fever, its Successful Treatment, 1899; Thorington—Refraction and How to Refract, 1900; Ostrom—Massage and the Swedish Movements, 1899; Bramwell—Anaemia and Some of the Diseases of the Blood-Forming Organs and Ductless Glands, 1899; Fullerton—Surgical Nursing, 1899; Lewis—Mental Diseases; Smith-Eustace—Wasting Diseases of Infants and Children, 1899; Coblentz—The Newer Remedies, 1899; Thorne—The Schott Methods of the Treatment of Chronic Diseases of the Heart, 1899; Knopf—Phophylaxis and Treatment of Pulmonic Tuberculosis, 1899; Goodno—Practice of Medicine, 2 vols., 1897; Bradford—Logic of Figures, 1900;

Dunham—Science of Therapeutics; Dennis—System of Surgery, 4 vols., 1897; Bradford, T. L.—Pioneers of Homoeopathy, 1897; Bradford & Lovett—Orthopedic Surgery, 1899; Fisher's Diseases of Children, 1895; Bradford—History of Hahnemann Medical College and Hospital of Philadelphia, 1898; Fisher & MacDonald Homoeopathic Text-Book of Surgery, 1896; Brunton—Lectures on the Action of Medicines, 1898; Solly—A Hand-Book of Medical Climatology, 1897; Treves, Frederick—Manual of Operative Surgery, 2 vols., 1892; Wilson, J. C.—Fever Nursing; Mills, Chas. K.—Nursing and Care of the Nervous and Insane, 1897; Bartley, E. H.—Text-Book of Medical and Pharmaceutical Chemistry, 1898. From Dr. Bruner: Fuchs, E.—Text-Book of Ophthalmology.

**Syphilis from Dental Instruments.** Wm. L. Baum (*Jour. Am. Med. Assoc.*) reports six cases of syphilis, in five of which the infection is attributed to wounds from dental instruments, and in the sixth case to an instrument (tonsillitome) in the hands of a physician who never boiled his instruments. He divides syphilitic manifestations in the mouth into three kinds: (1) The initial lesion, or chancre, which may appear on the lips, tongue, tonsils, or fauces; (2) secondary lesions, such as erythematous or papular syphilides, which occur on the velum, the palate and the tongue; (3) tertiary symptoms, such as gumma, which may attack the tonsils, uvula, soft palate, or tongue. The writer gives a description of the different lesions as they appear when found in the mouth. All dentists should have a knowledge of the characteristic appearance of the different syphilitic lesions and should also make a practice of boiling all their instruments.—*Medical News*.

**Seasickness.** Seasickness is defined by J. Carlisle De Vries (*Indian Med. Record*) as "a peculiar functional disturbance of the nervous system, produced by shock resulting from the motion of the ship." He does not consider it a disease of the stomach or alimentary canal, but clearly a functional disease of the central nervous system. The disturbance is divided by him into four stages, viz., depression, exhaustion, reaction, and convalescence. The symptoms begin with a general depression followed by giddiness, nausea, vomiting, and derangements of the bowels and urinary secretion. An abnormal appetite often precedes the stage

of depression. As to the treatment, sometimes a deep inspiration simultaneous with the rise of the vessel, followed by expiration as it descends, will ward off seasickness. The writer has not seen any good results from bromide treatment. To lessen the likelihood of an attack the bowels must be opened the day before embarking by calomel, sodium phosphate, or a saline purge, and about twenty grains of sodium bromide taken at about 7 a. m. the day of sailing. One should remain on deck throughout the voyage and partake freely of mineral waters. When one has not taken this preliminary treatment aromatic drinks, lemonade, champagne, and ginger ale prove of great value. A horizontal position should be maintained, and a general plain diet, but no cold food should be taken. Give brandy or wine if stimulation is needed. If confined to stateroom a spinal ice-bag relieves the spinal congestion. In obstinate cases nitrate of amyl given in full doses on the first appearance of epigastric distress is beneficial. When everything else fails, morphine may be given to relieve the retching, but should be given carefully. The writer's experience was gained in 58 transatlantic voyages.—*Medical News*.

**Surgery of Typhoid Perforations.** W. W. Keen (*Jour. Am. Med. Assoc.*) says that operation is the procedure of choice in treating typhoid perforation, except in the few patients whose condition is such that recovery is hopeless. Patients have been operated on three times and yet recovered. Age seems to affect the recovery rate. Thirteen under 15 years of age gave nearly 54 per cent. recoveries; 43 from 15 to 25 years of age, 9.3 per cent.; 43, 25 to 35 years of age, 23 per cent., and 20 cases over 35 years, 30 per cent. The female sex has a higher percentage of recovery, 42 per cent. in 20 cases, whereas 106 male cases only 18 per cent. recovered. Perforation in the fourth week has given 33 per cent. recovery, while in the third week only 16 per cent. recover. The best time to operate is as soon as possible after perforation, but not during profound shock. The statistics show that operation during the second twelve hours has given the best results up to this time. While waiting for reaction for shock peritoneal infection is increasing. The avoidance of both these evils depends on advance in two directions, the possible diagnosis of impending perforation, and exploratory operation under cocaine. The use of cocaine instead of a general anesthetic is the most important recent advance in technic. The incision under cocaine is best



made in the right linea semilunaris or through the rectus. The perforation should be sought in the ileum, in the cecum and appendix, or in the sigmoid. The perforation should be closed, without paring the edges, by a mattress suture, and if necessary, with a superimposed continuous suture. Thinned areas threatening to perforate should be inverted and sutured. With extensive or adjacent perforations resection and anastomosis may be required. Drainage is usually required, but if the case is not of too long standing and the peritoneum can be well cleansed, it is better to fill the cavity with salt solution and close without drainage. Speed is important, but not at the expense of careful work.—*Medical News.*

**Laryngeal Complications of Typhoid.** Peculiar affections of the larynx during the course of typhoid fever have been reported rarely and have been classed as (1) edematous laryngitis, (2) ulcerative laryngitis and (3) laryngeal perichondritis. R. M. Marsden (*Medical Chronicle*) has described three cases, one of which belongs to the first class, the other two ending as a perichondritis, which may have been secondary to ulceration. The peculiarities of the cases were that they came on late in the disease, with trivial symptoms of cough and hoarseness until the disease was far advanced, with no discharge of pus or cartilage, but resulting in such marked thickening in and around the vocal cords that the obstruction demanded tracheotomy in each case. The after-treatment of persistent and systematic dilatation was tried with only slight success, the fixation of the cords preventing much improvement in phonation. Where the arytenoids and cords are movable, and when a cannula has been introduced, the patient can speak with a fair voice, it is well to persevere with dilatation.—*Medical News.*

**Diagnosis of Gastric Ulcer.** F. H. Murdoch (*Phila. Med. Jour.*) says that the most important point in the diagnosis of gastric ulcer is to think of ulcer. He reviews the symptoms of the disease and cites some cases. Hemorrhage and the peculiar epigastric pain are the most important. He lays special stress on the importance of the circumscribed tender spots found in front over the stomach and the corresponding tender spot in the back to the left of the twelfth dorsal vertebra. He says that if, in a patient with dyspeptic symptoms, a small circumscribed spot of tenderness in the epigastrium is found it is justifiable to make a

diagnosis of gastric ulcer, whether there has been pain or hemorrhage or not. This tender spot, however, must be constant, not present one day and absent the next. This tenderness lasts for months sometimes and it is not safe to give solid food while it is present. General tenderness over the stomach is uncommon.

Orthoform promptly relieves the pain of gastric ulcer and because of this is a valuable aid in making a diagnosis. The writer concludes that in patients with dyspeptic symptoms, gastric ulcer may be diagnosticated positively in one of three ways: (1) By the occurrence of hemorrhage from the stomach; (2) by the presence of severe pain relieved by orthoform; (3) by discovering a small, constant, circumscribed spot of tenderness in the epigastrium with or without a corresponding tender spot to the left of one of the lower dorsal vertebræ.—*Medical News*.

**Penetrating Injuries of the Eyeball.** Davidson (*Va. Med. Semi-Month.*) says that the importance of determining the presence or absence of a foreign body in the eye cannot be too strongly emphasized. A powerful electro-magnet is useful in the detection of iron or steel particles. The fact that a patient does not experience a painful sensation when approached to a large magnet does not exclude the presence of an offending metal. The particle may be lodged in the lens substance—a tissue having no nerve supply—or it may have remained in the vitreous sufficiently long for the enveloping exudations to become organized, the force of the magnet not being sufficient to bring the small particle of iron in contact with any sensitive structures.

Wounds located in the ciliary region are always to be regarded as of grave significance. The author believes that myotics should never be used in the treatment of eye injuries, and the administration of potassium iodid should be condemned as in "all other acute inflammations of the eye." Patients with penetrating wounds of the eye should be confined strictly to bed. Prolapsing uveal structures should be excised within the first twelve hours, if possible.—*The Chicago Clinic*.

**The Prevention and Treatment of Puerperal Eclampsia.** Edward P. Davis says the convulsions may be readily controlled by chloroform, large doses of morphine, veratrum viride, or nitrite of amyl. Recent observers estimate that in women subjected to no care during pregnancy one in eighty-five has eclampsia. The mortality varies from fifteen to twenty-five per cent.

Serum albumin is important only when in large amount and appearing with kidney debris. As a preventive measure the patient's excretion should be stimulated. An appropriate diet composed largely of milk, bread and butter, green vegetables, and fruit, with an abundance of pure and soft water, is the first prerequisite; a warm tub bath at night and a cool sponge in the morning should be taken. This wool or silk and wool should cover the entire surface. Fresh air and gentle exercise are necessary. Alcohol should not be allowed. The craving for tea or coffee may usually be appeased by the use of very hot water, effervescent drinks, and occasionally, for a short time, small doses of nuxvomica or strychnine.—*Med. Record.*

**Uterine Fibroid.** F. H. Champneys (*Lancet*) basing his statements chiefly on the records of five London hospitals, says that the mortality after operation for fibroids is 17 per cent., while the mortality of fibroids apart from operation is 3 in over 2,000,000, or a little over .0001 per cent. In the natural course of events, therefore, fibroid tumors do not cause death, and, therefore, it is not necessary to remove them. Whether or not their removal is desirable depends on the merits of each case. Severe recurrent bleedings may render surgical relief necessary. Severe pain also calls for relief. Dangerous pressure symptoms are usually those causing retention of urine, and call for immediate interference especially when accompanied by bleeding. A cystic fibroid grows persistently and should be removed. Malignant degeneration, although often talked of, is very rarely seen. There is a tendency at present to remove fibroids more freely. Operation is unjustifiable unless the fibroid is dangerous to life, or destructive of the patient's comfort and happiness, in which case the dangers of operation should be explained and the patient allowed to choose.—*Medical News.*

**Home Treatment of Consumption.** In probably 95 per cent. of all cases of consumption a change of climate, or life in a sanatorium, is impossible and they are confined to their own homes for treatment. Wm. Osler (*Maryland Med. Jour.*) says that the arrest, or cure, of tuberculosis is a question of nutrition entirely, and that the essential factor is to improve the resisting forces of the body so that the disease cannot make further progress, or is eradicated. Fresh air and good food are the most important means by which the nutrition may be increased. While the qual-



ity of the air in our cities may not be of the best, it is a great deal better than the atmosphere of the ill-ventilated and over-heated rooms in which a great number of phthisical cases live. The writer gives the following directions to his patients: In winter the patient is to be out-of-doors during all of the hours of sunshine except the first two in the morning and the last one at night. If out-of-door life is impossible, the patient should be in a room with southern exposure, with windows wide open, and the bed in the sunshine. If there is a balcony with southern exposure, the patient, well wrapped up, should sit or recline there on a comfortable lounge all day long, except when the weather is very rainy or stormy. The bedroom should be well ventilated at night and the patient gradually accustomed to have the window open. This continuous open-air life, at rest, has a wonderful influence over the fever of consumption. Often for a month, or perhaps two, or even three months, the temperature will be normal. Those patients do best who are able to take plenty of food. Lack of appetite and weak digestion are due in great part to the fever, therefore, as the temperature falls, the appetite often increases. Each patient should eat as much as he can, even to overfeeding, or stuffing, if possible. Besides the ordinary meals, Osler urges his patients to take raw eggs, beginning with one three times a day, and increasing one a week until they take perhaps 20 to 24 daily. This he finds the most satisfactory and simple diet for the hyper-alimentation. The egg, broken into a cup and seasoned with salt and pepper, can be swallowed without breaking the yolk. The main diet should consist of milk, cream, butter, eggs, meat and oysters. Osler divides the medicinal treatment into (1) the use of stomachics, bitter tonics and digestives; (2) cod-liver oil, hypophosphites and creosote for general nutrition, and (3) remedies for cough, pain, night sweats, etc.—*Medical News*.

**The Treatment of Aneurisms by Subcutaneous Gelatin injections.** Thomas B. Fitcher reports cases of aneurisms treated by gelatin, and draws the following conclusions from his experience: (1) In no case was the aneurism cured, although in one case of abdominal aneurism still under treatment there has been considerable diminution in size; (2) in seven cases out of nine there was an appreciable diminution of subjective symptoms; (3) it seems certain that the subcutaneous injection of gelatin does increase the coagulability of the blood; (4) the injections are fre-

quently very painful; (5) the injections were often followed by rise of temperature, although Lancereaux states the contrary from his experience; (6) although in no case has a cure yet been obtained, the author is convinced that the method has some merit and deserves further trial.—*Jour. Am. Med. Assn.*—*Med. Rec.*

**Local Anesthesia.**—A. E. Barker (*Lancet*) reports fifty-three cases, including radical cure of hernia, resection of intestine, gastro-enterostomy, goiter, wiring of patella, etc., in which local anesthesia by means of 1 to 1000 eucaïne B. in normal salt solution was used. For some patients as much as six ounces of this solution were used, with no ill effect. There is no interference with primary union. Children and timid adults are not adapted to its use, for they are frightened by the surgical surroundings. Acutely inflamed areas cannot be rendered entirely anesthetic. Dragging the mesentery causes a sense of pressure or griping.—*Medical News.*

**Tensile Strength of Sciatic.** Since the operation of stretching the sciatic nerve has been so frequently performed to relieve intractable sciatica, it is important and interesting to know how much strain upon the nerve is safe and advisable. W. E. Lower (*N. Y. Med. Jour.*) has tested the strength of the sciatic nerves of nine subjects shortly after death in a manner similar to that used in the operation of nerve-stretching. In one case the nerve gave way when only one hundred pounds had been used. The average weight required was one hundred and forty pounds. In most of the cases the nerve did not break, but its connections with the cord and membranes were detached.—*Medical News.*

**The Treatment of Eclampsia.** James Clifton Edgar takes up the first preventive, then the curative treatment, under which latter he discusses a method to control the convulsions. Among other things he advises that the uterus be emptied under deep anæsthesia by some method that is rapid and that will cause as little injury to the woman as possible. He then goes on to consider elimination of the poison or poisons which we presume cause the convulsions. A protest is entered against the careless use of the term "accouchement force," and to the easy confidence with which it has been recommended as the best if not the only means of controlling eclamptic seizures, without attaching sufficient importance to the condition of the cervical barrier.—*Med. Record.*

**The Medical Fraternity of Akron and Vicinity** held a social gathering and banquet at the Empire House, on Feb. 28th, under the auspices of the Celsus Club on the occasion of its sixth anniversary. A very pleasant and enjoyable evening was spent by all who were present.

**Syphilis of the Nervous System.** Syphilis is one of the most frequent infectious causes of organic nervous disease. Wm. M. Leszynsky (*Jour. Am. Med. Assoc.*) says that every morbid condition of the nervous system which may develop in a person is not necessarily due, however, to a syphilis acquired at some more or less remote period. A favorable prognosis does not necessarily follow the discovery that a lesion of the nervous system is of a luetic nature. It has been demonstrated by clinical experience that patients who have undergone a thorough and systematic anti-syphilitic treatment in the early stages of the disease are not insured thereby against subsequent syphilitic disease of the nervous system. Thus it seems that there is no remedy which will protect the nervous system against syphilis. When syphilis attacks the nervous system it affects it in several ways. (1) It may produce an endarteritis in the intracranial or spinal arteries, which gradually leads to thrombosis and occlusion of vessels. (2) It may give rise to a gumma or a local or diffuse gummatous exudate, which may gradually press upon, and finally destroy the nerve-cells or conducting fibers. (3) The cell substance may undergo degeneration because of a gradual interference with its nutrition. The first two forms, known as "inflammatory" or "exudative," often occur within the first two to three years, and may occur within a few months, after infection. They are more or less acute. The third form is called "degenerative" and is chronic. The forms of brain syphilis most dangerous to life are: (1) That which attacks the cerebral arteries, producing obliterative endarteritis, and (2) basal-meningitis and meningoencephalitis extending to the posterior fossa. The symptoms, which result from the destruction of nerve-cells, when they have persisted for months or years in spite of treatment, are those which are not amenable to further treatment of any kind. When a cerebral artery—it is most frequently the middle cerebral or its branches—becomes the seat of thrombosis, the nutrition of an area of the brain is interfered with, and there is a corresponding impairment of its physiologic function. The amount of disturbance depends upon the size of the vessel involved and of the area supplied by it, and upon



whether the occlusion is partial or complete. The cutting off of the blood supply of an area causes a necrotic softening which no antisyphilitic treatment can remedy. Cerebral hemorrhage causing destruction in the internal capsule may be due to the rupture of a syphilitic artery, but antisyphilitic remedies cannot repair the damage. In such conditions it is not only useless, but harmful, to persist in giving mercury or potassium iodide. It is in recent luetic inflammations that antisyphilitic remedies are of value. The rapidity of relief depends on the virulence of the disease, the character and duration of the symptoms, and upon the susceptibility of the patient to mercury and iodine.—*Medical News*.

**The Peculiar Christian Scientists.** In that sprightly, queer little "periodical of protest," called *The Philistine*, there appears this month a pitiable, illogical little reply to Mark Twain's recent *Cosmopolitan* article on the "Christian Science Fad and Delusion." Either the reasoning faculties of *Philistine* have become badly twisted, or else he is not sincere in what he says. He seems to lean to Christian Science. In the broad humor of Mark Twain there is clearly more sound sense than in the protesting seriousness of the whole of *Philistine's* article. Unlike Mark Twain, *Philistine* is full of mean sarcasm, vindictiveness and scarcely-concealed anger. *Philistine* says, "It is a well-known fact among all intelligent people, that Christian Scientists especially taboo eye-glasses of every sort and kind." Clearly *Philistine* knows less about Christian Scientists than does Mark Twain, whom he impertinently declares has never "associated with" or known them. The writer will be glad to introduce *Philistine* at any time to some of his friends, Christian Scientists, who wear glasses.

*Philistine* says he has seen people grievously ill "who were claimed back into health and usefulness when they renounced all material medicine and gave themselves into the hands of Christian Science." Very probably! There is a large class of people, well-known to physicians, who swallow a lot of needless medicine, when there is nothing the matter with them. Medicine taking, like Christian Science, may become a fad with some irrational neurotics and ignorant hysterics. But *Philistine* intends to convey the idea that these people were diseased physically, and by Christian Science have been made whole again physically. At once we assert, that neither *Philistine* himself, nor even the quondam patient is competent to decide such a question. *Apparent*

*cures are not real cures*, any more than relief from pain by a hypodermic injection of morphine is a cure. Only one who knows the nature of the disease, the means employed to modify it, and the nature of that modification, is at all competent to decide whether the patient has been cured or not. *Philistine*, and Christian Scientists generally, are presumptuous and egotistical in asserting facts about which they know absolutely nothing, not even the slightest elements.

*Philistine* grieves that Mark Twain does not appreciate more the lofty moral and religious teaching of Mrs. Eddy and her cult, and in consequence he devotes nearly all he has to say to a commendation of Christian Science as a religion. There *Philistine*, like all Christian Scientists, reveals the wabbling condition of his reasoning faculties. The dispute is not with Christian Science as a religion, or a system of morals, or a simple belief; the dispute with it is solely on the ground of its capability to handle physical changes, known as organic disease, in our physical bodies. An easy way to dodge and escape this hard thrust is of course to deny the physical body, and that is the cowardly way that Christian Science escapes. All discussion, of course, ceases the moment one or the other side denies the reality of its opponent. That is magnificent strategy, but it is not fair, honest, logical, reasonable, scientific or Christian. Science loves to discuss and compare, and Christ hesitated not to reason together with His opponents.—*The Medical Fortnightly*.

## Counter-Irritants.

## Practice.

*Old Doctor* (to *Young Beginner*): "Are you having much practice now?"

*Young Beginner*: "Yes, sir; a great deal, thank you."

*Old Doctor*: "Ah, I am glad to hear it. In what line is your practice particularly?"

*Young Beginner*: "Well, sir; particularly in economy."

Magistrate to a witness: "What is your profession?" "A lawyer." "Well, try to forget it while you are giving your testimony."

*Young Doctor* (exultantly): Well, I've been successful with my first patient.

*Old Doctor*: Of what did you relieve him?

*Young Doctor*: Ten dollars.—*From N. Y. Lancet.*

*Mrs. Dukane*: I read the other day of a queer fish called the candle fish. It is caught in the waters of Puget Sound. These fish are so oily that they burn like candles.

*Mr. Dukane*: Can they be eaten?

*Mrs. Dukane*: Oh, yes; but they make a light diet.—*Pittsburg Chronicle-Telegraph.*

## Lovely Woman.

*Askit*: When does a woman demonstrate that she has a way of her own?

*Tellit*: When she can't have her own way.—*Baltimore American.*

*Teacher*: "Astronomy is a wonderful science, Harry. Men have learned through it not only how far off the stars are from the earth, but what they are made of."

*Harry*: "It seems to me a great deal more wonderful how they found out their names."—*Harper's Round Table.*

"Say," said the doctor, addressing the druggist and winking knowingly at the clerk, "do you know anything about this stamp tax?"

"Sure," replied the druggist. "What do you want to know?"

"Suppose," continued the M. D., "that I wanted to express my opinion; would I have to stamp the express receipt?"

"Undoubtedly," answered the druggist. "But if you will allow me, I would suggest that you forward your opinions by mail!"

"And why by mail?" asked the autocrat of physic.

"Because," replied the dispenser, "as they would have no weight it would be much cheaper."—*N. Y. Lancet.*



## Bigamy Prohibited.

"Boys," said the superintendent of a Sunday-school, "can any of you quote a verse from Scripture to prove that it is wrong for a man to have two wives?" He paused, and after a moment or two, a bright boy raised his hand. "Well, Thomas?" said the teacher encouragingly. Thomas stood up and said, "No man can serve two masters." The question ended there.

Chicago is determined to have a finer library building than Boston, even if it has to hire persons to sit in the rooms and do the reading.—*New York Evening Sun*.

"A fine sermon that," said Deacon Brown, who was a great admirer of the parson, "a fine sermon, and well-timed, too." "Yes," answered Mr. Synnek, "it was certainly well-timed. About half the congregation had their watches out."—*Transcript*.

"O doctor, I have sent for you, certainly. Still, I must confess that I have not the slightest faith in modern medical science." "Oh, that doesn't matter in the least. You see, a mule has no faith in the veterinary surgeon, and yet he cures him all the same."—*Tagliche Rundschau*.

## Take Heed.

*Watts*: "Doctor, do you believe that the use of tobacco tends to shorten a man's days?"

*Dr. Bowles*: "I know it does; I tried to quit once, and the days were about eighty hours long."—*Medical Dial*.

A big Yankee from Maine, on paying his bill in a London restaurant, was told that the sum put down didn't include the waiter. "Wal," he roared, "I didn't eat any waiter, did I?"—*Universalist Herald*.

"Well," said Yuss, "I've taken a powder for my headache, a pellet for my liver, and a capsule for my gouty foot. Now what puzzles me is how do the things know the right place to go after they get inside."—*Philadelphia American*.

A couple of lawyers engaged in a case were recently discussing the issue. "At all events," said the younger and more enthusiastic, "we have justice on our side." To which the older and wavier replied, "Quite true; but what we want is the chief justice on our side."—*Exchange*.

Lowell was once in Italy with a young man, who tried to tell a beggar to go to the devil. He meant to say *Andate al Diavolo*; but, unfortunately, his first word was *Andiamo*, "Let us go." At this the beggar took off his hat, and told how delighted he should be to go anywhere in such good company.—*New England Magazine*.

### A Slight Mistake.

This is an instance when a bad cold caused a startling conversation. A modest young newspaper man was invited to a party at a residence where the home had recently been blessed with an addition to the family. Accompanied by his best girl, he met the hostess at the door, and after customary salutations asked after the baby. The lady was suffering from a severe cold, which made her slightly deaf, and she mistakenly supposed that he was inquiring about her cold. She replied, that, though she usually had one every winter, this was the worst that she had ever had; it kept her awake at night a great deal at first and confined her to her bed. Then, noticing that the scribe was becoming pale and nervous, she said that she could see by his looks that he was going to have one just like hers, and asked him if he wished to lie down. The paper came out as usual the next week, but the editor has given up inquiring about babies.—*Medical Record*.

At the Little Rock (Ark.) Telephone Exchange lately, a call came in from a residence for a feed store. "Hello!" "Hello! What is it?" "Mamma says send up a sack of oats and a bale of hay," in a child's voice. "Who is it for?" inquired the feed man. "Why, for the cow, of course," said the boy, and closed up.

### Preserving One's Health.

*Physician* (to patient): "You should take two grains of quinine every hour or half hour."

*Patient*: "Great Scott! Doctor, isn't that rather often?"

*Physician*: "No. Take it in a little whisky."

*Patient*: "All right. Two grains every—how often did you say?"

*Physician*: "Every hour or half hour."

*Patient*: "All right, doctor. Two grains every half hour."  
—*The Retail Druggist*.

A Scotch newspaper declares that a celebrated vocalist narrowly escaped with his life, his carriage having been upset near Edinburgh; but he was able to appear the same evening in three pieces.

"Step right in, ladies and gentlemen!" cried the showman. "Step right in, and see the educated pig add and subtract." "Pshaw!" interrupted Farmer Backlots. "My old hog at home has got way over to square root."—*Texas Siftings*.

*Master of the House* (slapping his clothes vigorously): "Bridget, why didn't you dust my study chair?"

*Bridget*: "Shure, sorr, Oi knew yez would be sittin' down in it prisently, and Oi thought it wasn't ninessary."—*Burlington Free Press*.

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## Original Articles.

### THE DIAGNOSIS AND TREATMENT OF CONGENITAL DISLOCATION OF THE HIP.\*

BY WILLIAM E. WIRT, A. M., M. D., PH. D.

Professor of Orthopedic Surgery in the Cleveland College of Physicians and Surgeons; Orthopedic Surgeon to Cleveland General and Cleveland City Hospitals; Member of the American Orthopedic Association.

The treatment of a physical ailment or deformity, which until a few years ago was considered practically incurable, must necessarily have about it attributes of interest to the average practitioner. This assertion can be truly made of congenital dislocation of the hip, and while at the present time, many, if not a large proportion of these children, if the sum total is considered, are still allowed to grow up with the deformity, yet it may rightly be claimed that if they were seen and treated at an early period in their life, a cure in a majority of these cases might be brought about.

The frequency of this affection is a subject upon which there is considerable difference of opinion. Statistics on this point vary so greatly that it is nearly impossible to determine the relative frequency of this disease to other surgical affections.

The Hospital for Kuptured and Crippled, New York City, an institution that treats about 9,000 patients a year, had only twenty cases recorded for their annual report of 1890. From Young's Orthopedic Surgery I quote the following:

"Its relative frequency is a little less than one in a hundred surgical cases. \* \* \* Of nineteen cases treated by Hoffa, four-

\* Read before the North Western Ohio District Medical Society at the meeting held at Findlay, Dec. 6-8, 1899.



teen were girls, and five were boys; twelve were double, and seven were single. Dollinger in 859 cases of deformity found there were nine cases of this affection, or 1.1 per cent., but Hoffa in 1444 orthopedic cases found only 7, or .49 per cent. Chaussier, in 23,292 new-born children at the Paris Maternity, found only one case, whereas Parise found it three times in 332 autopsies upon new-born children at the Hôpital des Enfants Trouvés."

The above statements show how widely divergent the statistics are on the subject.

Howard Marsh, F. R. C. S., in speaking of this subject, says: "It is far from uncommon and is met with in individuals who are otherwise healthy. \* \* \* It is on account of its *reputed* rarity and the obscurity of its features in many instances, apt to be overlooked or mistaken for some other affection of an entirely different kind."

My own experience would lead me to thoroughly agree with Howard Marsh that it is frequently overlooked, and that it is much more common than is usually supposed. In 1895 I saw seven new cases of congenital dislocation of the hip during the month of July. This is certainly an unusually large number to be seen by one observer in so short a time.

In confirmation of the statement that in many instances this condition is overlooked, or mistaken for some other affection, I wish to report the following cases, some of which show the importance of making a thorough examination, and that error often results from hurry or carelessness.

Case I. Within the first day or two after I arrived in Cleveland to take up the practice of medicine, a leading surgeon sent me a case suffering, as he supposed, from Pott's disease, and in his note to me described it as a peculiar case of that kind. The next day on meeting me he was very much surprised to learn that I had found it to be a case of congenital hip dislocation. Our learned and honored professor of surgery had missed the diagnosis by a superficial examination.

Case II. Within six weeks this same gentleman sent me a case suffering from infantile paralysis, but the additional ailment of dislocation of one hip had been overlooked.

Case III. From my paper on Congenital Dislocation of the Hip, published in the CLEVELAND MEDICAL GAZETTE in 1891, I quote the following: "A girl, about 7 years of age, from out of town, was referred to me by attending physician. The diagnosis of infantile paralysis had been correctly made, but the extreme

anterior bending of the lower part of spine (lordosis) as well as the peculiar walk of the child had not been accounted for. The child wore "long springs" or braces for weak ankles resulting from the paralysis. On stripping the child and having her walk and run across the room, the symptoms of very marked lordosis, wabbling gait and prominent hips, became very apparent. By a further examination I was able to diagnose congenital dislocation of both hips."

Cases IV and V. I am reminded of two sisters who were referred to me by the family physician as peculiar cases of spinal disease. I was in a certain town of northern Ohio attending a patient of mine, and while there had my time taken up by examining a number of cripples, among them the sisters above mentioned. The doctor was very much surprised to learn that both these girls, seven and eleven years old, were suffering from congenital dislocation of both hips.

Case VI. At the same time I saw cases IV and V, a boy 7 years old was brought to me thought to be suffering from hip disease. An unquestionable diagnosis of congenital dislocation of the left hip was made.

Case VII. On December 19th, 1898, Anna B., age  $2\frac{1}{2}$ , was sent to me by the family doctor with the diagnosis of infantile paralysis of the right limb. I examined the child and saw that the diagnosis was perfectly correct. I discussed the case, and outlined a course of treatment, after which I was just about to tell the father to put on the child's shoe, but changed my mind and said, "I will examine the child thoroughly." I stripped the child and immediately noticed that the left or well limb was the shorter. The child was two and a half years old and could not walk. Delayed walking is generally due to one of three things: infantile paralysis, congenital dislocation of the hip, or rickets. Here we had infantile paralysis to account for the child not walking, and the fact nearly led me to overlook the main affliction. On further examination I found, besides the shortened limb, that the left hip was also more prominent than the right, and that the trochanter major on that side was one inch above Nelaton's line. On manipulation I found crepitation, and so made out a diagnosis of congenital dislocation of the left hip. Afterwards I saw the family physician, who, in speaking of the case, said, "I have examined the case since you saw it, and I differ from you; the child has not dislocation of the left hip." I replied, "We are all entitled to our opinions, but I am positive that the child has dislocation of

the hip." In June, six months later, the child started to walk, and the left limb became much shortened, so that when the father and doctor brought the child to my office in July I was able to convince both that my original diagnosis was correct.

Case VIII. In March of this year one of our post graduate students at the College of P. and S., who had been in practice a number of years, brought to my clinic a case of supposed spinal curvature that had worn P. P. jackets for correction of the spinal complaint. The spine had a very marked anterior bending so that the senior class, in their discussion of the case, gave all their attention to the spine. It was easy to diagnose a congenital dislocation of both hips.

Case IX. July 9th of this year a girl, 14 years old, from Canton, Ohio, while visiting in Cleveland, was brought to me for treatment of her spine. Her mother said that the girl had spinal curvature, and she understood I was giving gymnastic treatment and massage to such cases; that she understood what should be done in such a case, and that she only came to make arrangements about the treatment. I informed the lady that I had never treated a case without an examination. She replied that an examination was unnecessary, that there was no question about its being spinal curvature, and mentioned a prominent Cleveland surgeon, besides others who had examined the case at various times in the past, and who had applied jackets for the relief of the spinal complaint. I insisted that I would not treat the child without an examination, at the same time stating that there was something about the child's walk that made me think it was not spinal curvature. Finally upon the advice of a lady friend, who was with the mother, an examination of the girl was agreed upon. On stripping the child I found that both hips were quite prominent, the abdomen was prominent, and there was marked spinal lordosis, making the mother and others think that it was spinal difficulty. I found the great trochanter on both sides two inches above Nelaton's line, so that the diagnosis without question was congenital dislocation of both hips.

Case X. Oct. 27, 1899, a child 4 years old was brought to my clinic, the peculiar gait having been ascribed to "softening of the bones" (meaning rickets) by one observer, spinal curvature by another, etc. I saw the child take three steps before the class, and made the snap diagnosis to the students of congenital dislocation of the hips. On a thorough examination all the character-



istic evidences of congenital dislocation of both hips were easily found.

I have here briefly described ten cases in which the proper diagnosis had not been made in congenital dislocation of the hip; but I am quite sure that had there been a careful examination, or had the observer's attention been attracted to this disability, the diagnosis in several of them would easily have been made. This number ten is by no means all the mistakes in diagnosing this affection that have come to my notice, but it is quite sufficient to illustrate my point.

In order that we may more thoroughly understand the symptoms, their causes, etc., in this affection, I will briefly outline the pathological changes existing.

At the time when these cases usually come under observation the following conditions generally exist: There is an acetabulum with a more or less imperfect rim; or the rim may be entirely wanting, and even the site of the acetabulum may be indefinite and uncertain. The head of the femur may be entirely absent, or it may be normal, though usually some grade of abnormality is present. The neck of the femur is shorter and more horizontal than usual, and along with the head is frequently absent. The ligamentum teres is generally elongated, and when it helps to sustain the body weight becomes much hypertrophied. The capsular ligament may be found loose and unrecognizable, or, when it has sustained weight, thickened and stretched. The usual form of dislocation is upward and backward on the dorsum of the ilium; sometimes, though rarely, the dislocation is forward or downward. Above and behind the true site of the acetabulum a new growth of bone may be found, forming an upper rim to the new socket. New attachments are formed by the capsular and terres ligaments.

The pelvis is supported by the new acetabulum, by the terres and capsular ligaments, the peri-trochanteric muscles, and even the psoas and iliacus may assist in the work, the amount borne by the different parts varying in different cases.

In the usual case of upward and backward dislocation, the point of suspension is posterior to that of the normal hip, i. e., posterior to the center of gravity, and the resulting downward tilt of the anterior portion of the pelvis causing a bending forward of the spine, or lordosis, is but obedience to the laws of gravitation. In the few cases in which the dislocation is forward lordosis is entirely wanting.

*Diagnosis.* The diagnosis of congenital dislocation of the hip or hips is based upon the following symptoms, viz.: the attitude of the child while standing, the peculiarity of the gait in walking, the prominent hip or hips, shortening of the limb, if single dislocation, pain, delayed walking, limitations in the motions of the joint, crepitation, movement sometimes of the head of the bone over the pelvis, and above all the relation of the head of the bone to Nelaton's line.

The affection very commonly remains unnoticed until the child begins to walk, though observing parents often discover that something is wrong before this time, especially if it is a single dislocation, in which case the shortness of the dislocated limb will attract attention.

These children begin walking at a later period than that of the perfectly developed child, the delay being frequently as late as up to the third year and even longer, though on the other hand they may learn to walk at nearly the usual period.

The walk of these children is very characteristic in the typical cases. It is a wabbling or duck-like movement in which at each step the hips are thrown from one side to the other. In running the gait very much resembles that of a cow and is about as awkward. In single dislocation the waddling is not so great; it then becomes a marked limp.

In standing the most noticeable abnormality is that of anterior incurvation of the spine or lordosis. This lordosis is usually present, but not always. The trochanter is noticeably prominent; this is especially marked if the dislocation is single, in which case the contrast between the normal and dislocated hip becomes very apparent. If the dislocation is unilateral, one leg becomes shorter than the other, a tilting of the pelvis will be observed.

To make a thorough examination the child should be stripped. The child is made to walk and run across the room several times, to pick up articles off the floor, etc., whereupon the waddling gait, the lordosis, the prominent hips, and if unilateral, the tilting pelvis will become at once apparent.

The child then placed on a lounge or table and a careful physical examination made, the other diagnostic points can be readily made out.

If the case is one of unilateral dislocation a difference in the length of the two limbs will be found, and may be determined by measuring from the anterior superior spine of the ilium to the

inner malleolus for each limb. In a double dislocation this measurement may be the same for either limb, though not necessarily.

On manipulation the head of the femur may be moved about, frequently over quite an arc, and by steady traction the length of the limb may be increased by an appreciable amount.

Movements of the limb may be nearly normal, that of flexion and extension quite so. The movement usually restricted is that of external rotation, which is due to the dislocation being upward and backward, the head of the bone preventing complete external rotation.

Crepitation is frequently found; this may be tendinous or bony. But the most important diagnostic point is the relation which the great trochanter bears to Nelaton's line. Nelaton's line, as we know, is a line passed from the tuberosity of the ischium over the outside of the hip to the anterior superior spine. In the normal hip the trochanter is found directly on this line, or in some cases very slightly below it. In the dislocated hip this relation is disturbed. In a very large per cent. of these cases the trochanter is found distinctly above this line, frequently as much as an inch or more. In adults it may be as much as three inches above this line.

In those cases in which the deformity is of a mild grade and where the symptoms are more or less obscure, the diseases with which it may be confounded are: Infantile paralysis, acute arthritis of infants (results of), rickets, hip disease, and spinal affections.

In infantile paralysis the great laxity of ligaments, and the paralysis itself, may produce such a gait in the child as to simulate congenital dislocation, and indeed the laxity of the ligaments may permit such a dislocation. But in those not dislocated the trochanter will be on Nelaton's line, the limb will be cold and wasted, the reflexes absent, and all the joints of the limb lax.

In a hip joint destroyed by acute arthritis we have the history of a very acute attack of inflammation in the joint; we find scars, the result of discharge of pus from the joint, or from the surgeon's knife in letting it out—points which easily differentiate it from the congenital affection.

In rickets the child walks with a waddling gait, and in many cases stands with the spine considerably lordosed. But the position of the trochanters on Nelaton's line and the diagnostic points of rickets, beaded ribs, enlarged epiphyses, etc., will leave no doubt in the mind of the surgeon.



Congenital dislocation of the hip has been treated as a case of hip disease; but why this is so is hard to understand. The position of the trochanters, the lack of pain, of muscular spasm and rigidity are points which ought to be hard to overlook.

That these cases are mistaken for cases of some spinal affection (not always clear in the mind of the examiner as to what form of spinal disease exists) is accounted for by the fact that on casual inspection the spinal deformity is the most appreciable symptom. But in Pott's disease of the vertebra the spine is always rigid, and deformity, when it exists is practically always kyphosis instead of lordosis, as seen in dislocated hips. In lateral curvature of the spine the curvature is always to one side or the other, besides there being posterior deformity, lordosis very seldom existing; and in both conditions the relation of the great trochanters is normal as regards to Nelaton's line.

*Treatment.* The treatment of congenital dislocation of the hip, until quite recent years, has been very unsatisfactory. Formerly the surgeon relied almost entirely on mechanical means, the usual method being that of traction and fixation, which was kept up for many months. In this way cures in a considerable number of cases were reported as having been obtained; but later, upon being examined by an impartial jury—a committee from some medical society—the almost universal report has been, "Improvement, but not a cure" The well-known case of Dr. Buckminster Brown, of Boston, is a good example illustrating the above statement. Dr. Brown kept a child's hips in fixation appliances for twenty-two months, and later it was reported as a perfect cure. This case is referred to, and is illustrated in most of the text books on bone and joint surgery. The patient is now a grown woman, and competent authorities have reported the case as having completely relapsed.

Many operative measures have been devised for the cure of this affection, as for example the injection of chloride of zinc about the head of the femur for the purpose of causing by irritation the formation of a bony ring; subtrochanteric osteotomy in selected cases; excision of the head of bone; the forcible reduction method of Paci under anesthesia; excision of the head of bone, and then nailing the great trochanter to the pelvis, etc., but most of these operations have been abandoned as being of no avail, or as actually leaving the child in a worse condition than before the operation, or again from the high mortality rate.

At the present time there are only two of the many operations or procedures that have been tried that are worth our while considering, viz.: the reposition of the head of the bone under anesthesia according to the method laid down by Lorenz, of Vienna; and the cutting operation by Hoffa, as modified by Lorenz and Whitman, of New York.

The method of Lorenz is as follows: The head of the femur is brought down to the level of the acetabulum by manual or mechanical force. Lorenz claims that usually this can be accomplished in a few minutes; my own experience has been that it requires considerable time and force. The trochanter major should be brought a little below Nelaton's line, with the head of the bone well to the inner side of the anterior superior spine of the ilium. The necessary mechanical force is obtained by means of a screw appliance pulling upon adhesive plasters applied to the limb, the counter force being a perineal strap secured to the upper end of the operating table. The second step of the operation, called *reposition*, is considered the most difficult part of the proceeding. The thigh is flexed upon the pelvis to less than a right angle, bringing the head of the bone to a position posterior to the acetabulum. The thigh is then gradually abducted with one hand, while with the other the head of the femur is guided and directed in the direction of the acetabulum. When abduction to a position of from 60 to 90 degrees has been reached, in the successful cases an audible sound—a distinct click—is heard as the head of the bone passes over the rim and drops into the acetabulum, at the same time a slight jarring sensation is felt by those who are holding the child. Abduction of the limb to any considerable extent at this time causes a redislocation of the hip, so that it is necessary to put the limb up in plaster of paris in extreme abduction. Within three or four weeks the child is put on its feet, having the shoe on the other foot built up two to four inches in order to throw the pelvis over on to the replaced hip joint, since this position keeps the head of the bone more easily in place than any other, and the weight of the body helps to ream out the new acetabulum. At the end of three months or thereabouts the plaster is removed, and the joint tested as to its condition, this being followed by a new cast with the limb flexed and abducted to a less degree. A third plaster may be applied with the limb in a more nearly normal position, and the shoe on the well side less elevated. A slightly elevated shoe may be worn for some months after the removal of the plaster of paris.

The original operation devised by Hoffa of Werzberg for the correction of congenital dislocated hips consists in making an incision posterior to the great trochanter in a manner similar to the incision of Lengenbeck for excision. The muscles attached to the upper end of the femur connecting it with the pelvis are all cut, and the head of the bone is entirely freed. An acetabulum is scooped out of the pelvis at the normal position, the limb flexed, and the dislocation reduced.\*

Lorenz of Vienna has modified this operation of Hoffa by making the incision from the anterior superior spine of the ilium downwards and outwards between the tensor vagina femoris and the sartorius, thus reaching the joint from in front. The joint is scooped out, and by powerful manual or mechanical traction the head is brought down, and the dislocation reduced. Where there is considerable shortening, the hamstring tendons are cut, and the limb is fixed in a surgical dressing and plaster-of-paris; after four or five weeks passive motion is begun.

I desire to report four cases in which reduction by the bloodless method was attempted with success in two, and failure in the other two, and I shall refer to two other cases in which the cutting operation of Lorenz was performed.

It was my good fortune in my first attempt to reduce a congenital hip dislocation, by the bloodless Lorenz method, that I should find all the phenomena laid down by the author of the method. I was all the more surprised that this should be so from the fact that in the cutting operation I had not found the conditions to correspond with those given in the description of the method.

. Case XI. Olive H., eighteen months old, was brought to me March 22d, 1898, from Akron, Ohio, having been referred to me by Dr. J. W. Rabe. The child was born at the eighth month of pregnancy, the presentation was facial, and forceps were required in the delivery. The parents first noticed that something was wrong in the gait of the child when it first began to walk. The abnormality in the walk of the child became more and more pronounced as the child became older, and for six weeks prior to their visit to my office they had noticed "a bunch" over the location of the hip. The diagnosis had not as yet been made. On examination I made out the following points: The distance from the right anterior spine of the ilium to the inner malleolus was  $12\frac{1}{4}$  inches, on the left side it was 13 inches, the difference between the two sides being  $\frac{3}{4}$  of an inch. The trochanter major of



right femur was  $\frac{3}{4}$  inch above Nelaton's line. The walk of the child was characteristic of dislocated hip, so that a diagnosis of dislocation of the right hip was made.

May 10th, 1898, the child was put under chloroform, and the dislocation reduced. By means of a perineal strap and two assistants, the hips were held fixed while I used traction on the limbs, using simply manual force. It required a continuous pull for twenty-five minutes to bring the head of the femur down to the level of Nelaton's line, during which period measurements were made from time to time to see if sufficient traction had been made. At the end of this time, finding that the limb would temporarily remain at the proper level, I flexed the limb to a right angle, rotated it slightly inwards and strongly abducted according to the method of Lorenz, and was delighted to hear and feel it snap into place with the click described by the author of the operation. This slipping into place was distinctly heard by all those in the operating room, and was felt by those who held the child. On adducting the limb the head of the bone would slip out of place and on abducting it would again drop into the acetabulum. I had the assistants each place their hands on the femoral trochanter while the limb was abducted and adducted, and they were each absolutely certain that the head of the bone could be felt to rise up over the posterior wall of the acetabulum and then drop into the socket. The limb was placed in such a position of abduction that it was firmly retained in the acetabulum, and there fixed in plaster of paris. The child was seen for two or three days, and no untoward symptoms having occurred, and the limb appearing to remain in place, the patient was allowed to be taken home with the instruction that in three weeks the child might be put on its feet. The patient was to be brought to my private hospital for re-application of the plaster of paris at the end of two months. At the end of two months, the writer being away from Cleveland in the war, on the advice of their family physician the patient was taken to one of Cincinnati's distinguished surgeons. The plaster of paris was removed, the limb thoroughly examined, and the result pronounced a brilliant cure, and that nothing more need be done. The parents protested, against leaving the hip unprotected, correctly quoting me as saying that the hip would probably require to be protected for six months or longer. On the assurance of the surgeon that such protection was totally unnecessary the parents returned to their home with the child with the plaster left off. The child played about the

house and yard for six days, walking as the parents say without a limp, when suddenly from a misstep the child gave a scream and had a severe crying spell, and refused to use the limb for a week. During this time the mother tells me that simply touching the foot would make the child cry out. At the end of a week the child began gradually to use the limb, and in due time was again walking, but had after this the same limp as before the operation. It became apparent to the parents that the limb had again become dislocated, which opinion was confirmed by an examination made by their family physician. Following this, several surgeons were seen, but nothing was done for the child.

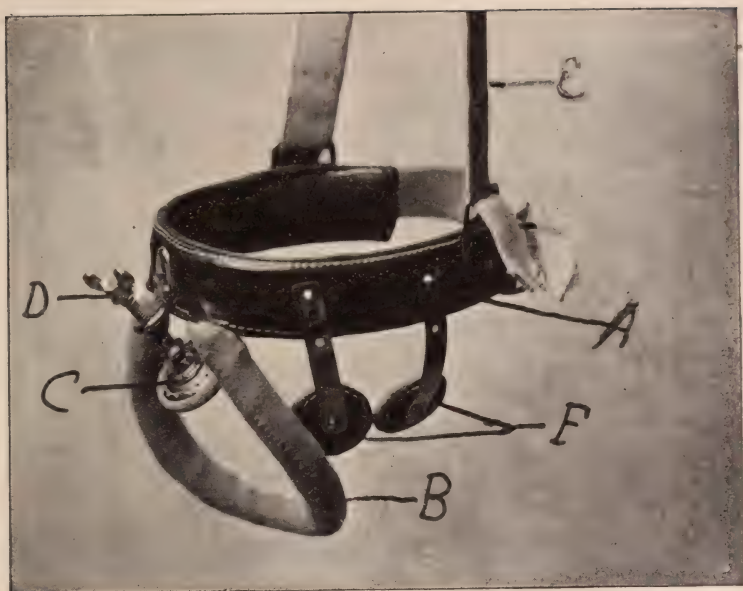
Oct. 6th, 1898, the family physician communicated the above facts regarding the case to me, and arrangements were made for a new operation. On examination I found that the limb was an inch shortened, and that the walk was fully as bad as before the operation. The child was put under chloroform, and the original operation repeated. All the phenomena related of the first operation were again repeated with one slight difference, and that was that the head of the bone would this time more readily jump out of the acetabulum, and it therefore required a greater degree of abduction of the thigh to keep it in place. The limb was put up in plaster of paris, and in two days the child was sent to her home with the understanding that I would, if possible, see her in January.

Dec. 29th the child was again brought to me, and the plaster removed. The limb was found to be firmly in place with a shortening between zero and  $\frac{1}{8}$  of an inch. The limb was again put up in plaster in a somewhat less abducted position. Measurements demonstrated the limb to be in place.

March 2nd I again saw the patient, and re-applied a plaster spica, bringing the leg still further down towards the normal position, the head of the femur still remaining in place.

May 3rd, 1899, the child was again brought to my office, and the plaster removed, and the child measured for a pelvic brace shown in cut I.

While Lorenz, the author of the operation, does not apply a protective brace after removing the plaster spica, yet in this case I was led to do so from the fact that already the hip-joint had been dislocated from lack of protection while walking after an apparent cure; and furthermore the parents were unwilling to again take any risks whatever, and preferred some apparatus to the further use of plaster of paris.



CUT I.



CUT III.





In cut I, A is the pelvic band; B is the perineal band of steel covered with a chamois; C is the pressure pad, cupped or hollowed out, well padded and regulated to press downward and inward against the trochanter major; D is the screw head which by turning forces the pad C against the trochanter; E is the suspender which prevents the left end of the pelvic band from being forced downward. The pads marked F are two hernia pads, the patient wearing this brace being so unfortunate as to have double oblique inguinal hernia.

In planning this brace I figured that the fulcrum of action in this brace would be at B, or rather the lowest part of the perineal ring, and that in forcing the pressure pad C downward, the reaction on C transmitted to the right end of the pelvic band would be upward. This would necessarily force the other end downward, and so I had the suspender attached to the left. It proved in practice that my conjecture was right, for the end at A was forced downward.

I am pleased to say that when applied the brace worked perfectly, the pad C pressing firmly down on the trochanter major. Cut II is a front view of the child wearing the brace. It can be seen that the child has the left shoe built up ( $2\frac{1}{2}$  inches). The child has worn this shoe for some months, which is done, as explained by Lorenz, to tip the pelvis in such a way that in walking the head of the femur on the diseased side will be forced more directly into the acetabulum, and so aids in preventing a re-dislocation. Cut III is a side view of the child and brace, and shows more clearly how the pad presses downwards and inwards on the trochanter.

After wearing the brace for a week I again saw the patient, and was told that at times when the child fell she was able to get up very readily. Motion was getting to be quite free in the hip, and the head of the bone is in normal position. Measurements were as follows: From the right anterior superior spine of ilium to right inner malleolus  $14\frac{5}{8}$  inches. On the left side this measurement is 14 6-8 inches. Difference in length of limbs is thus found to be  $\frac{1}{8}$  of an inch. I consider the child to be cured.

Case XII. Gladys Marie K., age  $4\frac{3}{4}$  years, was brought to me Feb. 1st, 1899, suffering from congenital dislocation of left hip. The patient was referred to me by Dr. Krause. I am informed that the child had two great-aunts who suffered from congenital dislocation of the hips. This latter point is given as

confirmation of the apparent fact that the affliction runs in certain families, i. e., that it is somewhat hereditary in character.

The child, the subject of this sketch, was slow in learning to walk, not accomplishing this feat until about the age of 2 years. The limp has been progressive in character, especially so during the last two years. Examination: In walking the child just touches the ball of foot to the floor, or again at times she drops onto the planter surface, thus producing the characteristic limp. The child tires easily. The right hip is rotated outwards about 10 degrees, and by use of force we find that 15 degrees more of outward rotation is permitted than in the left hip. By rolling the leg we find that slightly less rotation is permitted than in the left limb. The right trochanter major is  $1\frac{1}{2}$  inches above Nelaton's line. Ligamentous crepitus is felt on movement of the joint. By forced abduction of the thigh, and at the same time by forcing the limb upwards and outwards the trochanter major and head of bone are easily felt by palpation. The head of the bone is found to be of good size, and apparently nearly normal in its relation to the trochanter major.

March 1st the child is put under the influence of chloroform, and an attempt is made to replace the head of the femur into the acetabulum. By means of a long screw appliance attached to the foot of the operating table, and adhesive straps incorporating the entire limb, the latter is pulled upon with force of 150 to 200 pounds for a period of forty minutes. Counter-traction is made by means of a perineal attached to the head of the table. To relieve somewhat the pull on the ligaments of the knee I had my assistants pull from just above the knee for the lower pull, and from the pelvis for the upper pull. I would here state that I have been unable to verify Dr. Lorenz's statement that the limb can be easily pulled down to the normal position. In one case, in a girl 10 years old, where I followed Lorenz's cutting method of replacement, I used the above mentioned screw for thirty minutes or more before the operation, and then during the operation was again obliged to use great force for a considerable period. In a child 18 months old, where the cutting method was followed, it took four of us a considerable period to get the limb down.

In the case of the child under consideration, after a pull of forty minutes I attempted to replace the head of the femur, but was unable to do so, the femur not apparently being far enough down. The child was put in a plaster spica with the limb somewhat abducted.





CUT II.



A week later, March 8th, the child not having any untoward symptoms, she was again put under chloroform and a traction of 200 pounds applied for a period of sixty (60) minutes, measurements being taken from time to time to determine whether the limb was as long as its fellow. The amount of force used may be appreciated when it is understood that a strong man pulling his utmost could not relax the straps attached to the screw, showing that all the time more force than a man's strength was being used.

At the end of an hour the limb measured the full length of its fellow, and the head appeared in normal position, so that the screw attachments were removed, and attempt at replacement was made. The head of the femur could be placed in the acetabulum, but by manipulation this was felt to be but a small depression, and in no position of abduction was there stability of the limb.

The limb was put up in a plaster spica with the hope that even if the limb did not remain in this rudimentary cavity, that a better position of the head might obtain. No untoward symptoms followed the operation, and the child was ordered to be kept off the feet for four weeks. At the end of that time a high shoe was put on the other foot, and the child placed on its feet.

May 19th the plaster spica was removed and hip examined. the trochanter major was one inch above Nelaton's line, and the limb was an inch shortened. It was readily apparent that the limb had not remained in the rudimentary acetabulum; nevertheless there was a gain of half an inch in length. It was recommended that the child wear a hip brace to retain the increased length of limb, and if possible to make the amount of increase greater.

Case XIII. Ralph Edward B., age 8 months, was brought to me by Dr. Borts, of Cleveland, on Aug. 19th, 1899, with the following history: The labor at birth was difficult, forceps being required. Within a week the doctor noticed a redness over the hip joint, and a little later there was fluctuation. The abscess was opened and washed out, but no connection could be discovered between the abscess and the bone; the abscess was therefore thought to be superficial, possibly due to the forceps pressure, and the child was well within a month, all motions of the joint being fairly free. This abscess about the right hip called attention to the fact that the limb was somewhat shorter than its fellow, leading the doctor to make a diagnosis of dislocated hip.



On examination I made out the limb to be one-half inch shortened with trochanter major one-half inch above Nelaton's line. By extreme abduction and by pushing the trochanter outwards the head of femur in these dislocated cases can be readily made out; in this case I could find no head of bone; I therefore reasoned that there was probably no acetabulum, and informed the doctor and parents that the prognosis was bad, but recommended an attempt at replacement, as it could do no harm.

Immediately the child was put under chloroform and for fifty minutes the leg of this 8 months old child was pulled down upon with manual force of about 75 pounds by a relay of three assistants, at the end of which time the trochanter major was in the normal position. With my hand in the pelvic brim and thumb outside over the region of the acetabulum I could discover no acetabulum, nor evidence of a caput femori. The operation, therefore, was necessarily a failure. Within an hour after the operation the child was nursing and playing as usual. No symptoms whatever followed, resulting from the operation.

Case XIV. Hazel F., age 2 years, was sent to me Aug. 5th, 1899, by Dr. Burdick of Cleveland. The child began to walk at the age of 20 months. At first it was thought that the patient was simply weak in the leg, but later it appeared that the limb was short. On examination I found the limb three-fourths of an inch shorter than its fellow, with trochanter three-fourths of an inch above Nelaton's line. By palpation I found the head of bone of fair size, but the neck quite short. I gave the prognosis as fairly good for replacement under an anesthetic. Aug. 19th, immediately after the preceding case was taken from the table, this child was chloroformed and the traction machine applied. Traction of about 125 pounds was applied for 45 minutes, at which time the head of bone was found to be at the normal site. By manipulation the head of bone was forced into place, which was indicated by a snap heard by all those present. I re-dislocated and replaced the head of bone several times to demonstrate to Doctors Brokaw, Vale, Crow and others what was actually taking place. The limb was put up in plaster of paris in a flexed and abducted position, and is still in a plaster dressing, the child being allowed to get about after the expiration of four weeks.

I would briefly state in regard to the two cases previously referred to in which the cutting operation was done, that in the 18-months-old child the acetabulum was found fairly well formed, and a fairly good result was obtained. In the 11-year-old girl

only a mere roughness could be made out at the probable site of the acetabulum. A new acetabulum at this point of roughness was chiseled out. The mistake was made of allowing too many to examine the new formed acetabulum—at any event, the wound became septic, and the patient died. I consider one cause of the infection to be due to our efforts at the time of the operation to pull the limb down to its normal site. Lorenz in his first twelve operations was very unfortunate, all of them became septic and two died. He then did his operations at a private hospital instead of at a public clinic with much better results.

Lorenz used his traction appliances after opening the joint, and I think that this was possibly a factor, as in my case, in bringing about infection.

Whitman of New York City in a recent article on this operation considers active efforts at traction after opening the joint as materially increasing the probability of infecting the wound.

Whitman's modification of the Lorenz operation is to open the joint between the tensor vagina femoris and the glutius medius instead of between the former muscle and the satorius; he stretches the capsule with a strong cervix dilator.

Hoffa, as previously stated, cuts all the short muscles connecting the femur with the pelvis, on the grounds that they are the chief obstacle to reduction. Lorenz claims that these short muscles instead of being shortened in dislocation are actually stretched, and that it is the long muscles which cause the resistance, and he therefore advises that the long muscles—those going from the pelvis to the shaft of the bone and to the tibia—be tenotomized, and that the short muscles be preserved.

My plan is to use by manual or mechanical means all the force necessary to bring the head of bone to its normal site; in this case we know that we are elongating the proper muscles. This I do instead of cutting either the long or the short muscles with the possibility that the wrong set of muscles have been cut.

At the meeting of the American Orthopedic Association held in New York in June of this year, while discussing this subject, I was criticised by one operator for using the great traction force which I have reported in this paper. But in defense of this procedure I would say that so far I have not seen a single unpleasant symptom tracable to the severe traction; secondly, that the reduction of my cases could not have been accomplished with less force; and, thirdly, so long as the uncertainty exists as to which

are the shortened muscles I prefer to use the only method which elongates the unidentified shortened muscles.

Experience has taught us that the non-cutting reduction method is rarely effective after the age of 4 or 5, but is especially effective in infants, or those under 2 years of age. In cases of failure to reduce by this method, or in cases of relapse, the cutting operation of Lorenz, or as modified by Whitman should be done in children up to the age of 8 or 9; beyond this age it is not to be advised on account of the marked anatomical changes which have taken place. In all cases (of the proper age) the preliminary stretching should be done, using sufficient force to bring the trochanter major below Nelaton's line. In case of failure to reduce, and if the stretching has taken three-quarters of an hour or an hour's time, and there are evidences of shock, the cutting operation can be put off for twenty-four to forty-eight hours, time enough for complete recovery from shock, and before the muscles have recovered their tonicity and re-shortened the limb. The cutting operation will then be a short one, and with very few elements of danger.

The elements of danger remotely connected with this operation are relapse, adduction, flexion and limitation of motion. The relapse is best provided against by protecting the limb for some months after the operation. Plaster of paris I consider the best protection for the first few weeks. If neglected these patients may have considerable adduction or flexion deformity. To provide against this they must be strictly under the control of the surgeon, who must see to it that they have judicious passive motion and massage. If certain muscles tend to shorten they must be stretched from day to day. These cases are notable examples illustrating the fact that in this work the best results are obtained by a combination of operative and mechanical treatment.



FRAGMENTARY OBSERVATIONS OF THE PROGNOSIS  
OF BRAIN SYPHILIS\*

BY CHARLES J. ALDRICH, M. D., OF CLEVELAND, O.

Lecturer on Clinical Neurology and Anatomy of the Nervous System, College of Physicians and Surgeons; Visiting Physician and Neurologist to the Cleveland General Hospital and Dispensary;  
Neurologist to the Cleveland City Hospital.

Few diseases tax the prognostic and therapeutic resources of the physician more than brain syphilis. And the fragmentary remarks offered are, indeed, but a small part of a great question, yet it is hoped that they may interest the members and mayhap recall some forgotten knowledge of this not uncommon disease.

*Correct prognosis waits on accurate diagnosis:*

In no disease is this more true than in nerve syphilis. In speaking of diagnosis it is not meant a simple naming of the disease, but taking in with a wide grasp the character, progress, location and extent of the disease, giving due weight and consideration to the personal factor. A lack of vigilance or acumen is often responsible for the frequent slipshod diagnosis in nerve syphilis. These early mistakes materially increase the gravity of the prognosis. The ear that is stopped by ignorance or reprehensible carelessness is ill fitted to listen to the complaining prodroma of nerve syphilis pleading for the salvation and integrity of a threatened organ. Prognostic acumen comes only through wide knowledge and keen thoughtful bedside observation; and he that aspires to this the greatest and most difficult of all medical attainments, must ever be the student of detail and the observer of trifles. Therefore in making a forecast as to the probable outcome of a case of syphilis of the brain, we must bring to our aid, not only an accurate knowledge of the nervous system, but a complete understanding of the nature of the specific infection.

At the very outstart we are confronted by a very serious question: *Is the lesion caused by syphilis?* Upon a proper solution of this question depends the value of all our data. It is disconcerting to reflect that much of this data is rendered questionable by the accretions of three classes of observers. The first, and a despicable one, has left a heritage of what Tyndall called, "The scientific use of imagination," to be stumbling blocks along the whole way. The second has based his opinions and statements on the categorical answer of his patient to the question, Have you

\*Read at the May meeting of the Cuyahoga County Medical Association.

had syphilis? The third one is apt to lay at the door of the protean disorder every disease, accidental or consequential, which may attack man in his natural life. We have no words for the savage arraignment of the first of these observers. Of the last two, one is as bad as the other; one allows himself to be fooled, the other fools himself, while all three fool us all.

Data accumulated by such observers is trash, but they are such busy fellows and write so much! It is not alone in the bee colony that the drone makes the loudest buzz. For facts we must turn to the one that brings a mind well stored with the literature of the subject, uses all the knowledge of the acute clinician, depends little on any patient's statement, but more on his five senses and a thorough knowledge of the varied manifestations of the specific disease, its peculiar and nearly always recognizable mode of attack on the nervous structures of the body, and thus we will be enabled to winnow a few grains from the stacks of chaff and rubbish piled high by observers, if not dishonest, are at best one-eyed and see but the outline and mistake the nature of substance and shadow.

*The general laws of prognosis in acute brain disease hold good in acute specific lesions to a limited extent only.*

The reason for this lies in the fact that the phenomena produced by brain syphilis is so capricious, variable, and often incomplete as to constitute a distinct class. What other morbid process can we call to mind which will one day present such alarming symptoms as aphasia, coma, convulsions, or paralysis, and be absent the next? What other disorder will render a man four times aphasic, once deaf, partially blind, and three times hemiplegic, and then admit of recovery with only a slight halt as a souvenir of his experiences? Such a patient who had recovered from most of these afflictions under the able care of Dr. Lowman, wound up his experiences while with me, and has since remained well for a period of ten years, and filling with credit a very responsible position.

When, however, hemorrhage results from syphilis of a vessel we no longer have the cause but the result to deal with, and in no way does it differ in its immediate effects or final results from a hemorrhage from any other cause.

The same can be said of acute softening from any syphilitic process in the brain, it is only a secondary result, and in no way differs either in effect or prognosis from softening from other disease. In this connection it is well to remember what Wood says, "Prolonged deep stupor in persons suffering from cerebral syphi-

lis does not prove the existence of extensive brain softening, and is not incompatible with subsequent complete recovery; as an element of prognosis is of serious but not fatal import."

*Since we have the results of an infection to deal with that has little tendency to self-limitation, it must follow that both brain and cord lesions have a great tendency to relapse.*

This is especially true of brain syphilis. Early lesions of vascular origin are apt to be followed in later life by sclerotic processes and slowly developed degenerations. Collins has called especial attention to these facts, and as elements of prognosis should be remembered. It is frequently remarked in cases in which, in a comparatively short time after infection, the nervous system is attacked, yields to treatment, the patient is apparently cured, goes on in good health for years, when some symptoms evidently due to the irritative presence of the cicatrix of the old lesion appear along with proof of a renewal of activity of the specific process elsewhere in the brain or spinal cord. The prognosis in these cases is not good.

In giving a prognosis we should remember that every step of the highway of recovery from brain syphilis is beset by hidden dangers and deadly pitfalls into which the poor victim may suddenly tumble to the consternation of his friends and chagrin of his physician. It is a clinical fact that while one bit of syphilitic tissue exists within the brain its possessor will be liable to any one of those sudden accidents of anæmia, congestion, or inflammation which so often confound our predictions. To illustrate: a private patient about recovered from a specific hemiplegia, without warning began to have convulsions. One followed another until he had seven in four hours, and yielded only to a copious venesection. Recovery was prompt without increase of paralysis, but the memory was seriously and permanently impaired.

*Age, sex, social status, alcoholism, cachexia, and sexual excesses, all have vital prognostic importance.*

Women seem less liable to diseases of the middle cerebral arteries, and as gummatous meningeal and cortical diseases are less liable to fatal results, sex becomes an element in prognosis.

While infection by syphilis in youth conduces to the development of nerve syphilis, yet the elastic powers of recuperation which youth possesses is certainly a good prognostic. To the comparative youth of the victims of brain syphilis, I believe we owe a favorable tendency. It is pertinent to recall in this connection, that two-thirds of all cases of syphilitic softening of the brain



occur between the years of twenty and forty; being very rare before twenty and after fifty. Atheroma, on the other hand, is a disease which increases in frequency with each year of life beyond the middle term, and occurs rarely before forty. Thus we see that syphilitic obstruction of the arteries of the brain occurs at an age when the brain is in its period of greatest functional activity, and its nutritional channels widest; when compensation, and collateral circulation are most liable to take place; at an age when the action of medicines is most profound and when the processes of repair have their greatest activity.

Is it not reasonable to suppose that although certain brain tracts may be so deprived of blood as to inhibit function yet receive enough nourishment to maintain its structural integrity long enough for judicious treatment to remove the specific new growth which has occluded the artery?

Most clinicians agree that when syphilis is acquired late in life and attacks the nervous system, it does so with exceptional violence and malignancy.

The underfed, overworked, ill-clad poor, surrounded by unhygienic conditions, and unable to secure skilled treatment, must succumb more readily.

A life laden with syphilis and given to excesses of any kind is always in danger. *Alcohol and syphilis are the twin devils of pathology, which neither fleet-footed mercury can overtake nor iodine exorcise.* But the continued strain put upon the branches of the middle cerebral arteries by the licentious libertine who nightly seeks a new partner for his sexual carouse soon frees society of the diseased degenerate. Truly nature does not treat with her enemies.

The frequent death of men with degenerate arteries during the sexual act (usually illicit) brings to mind the cortical epilepsy of the jack rabbit that follows orgasm, and a like condition of the young stallion as he covers his first mare. These states are evidently due to a tremendous increase of tension in the cerebral arteries. Apropos to this I desire to record the belief that persons who are illicit, promiscuous, and excessive indulgers in sexual intercourse are peculiarly liable to syphilis of the brain.

*Syphilis of the nervous system as a pathological process differs in no way from syphilis elsewhere except as influenced by its histological environments.* This applies particularly to the specific affections of the nervous system which occur in the early stages of syphilis and not to those late manifestations of the disease as

represented by general paralysis and tabes dorsalis, and which some believe constitute a fourth stage of syphilitic disease. With the above limitations syphilis of the nervous system as syphilis *per se*, is as amenable to treatment as syphilitic disease elsewhere. Clinical experience has demonstrated that our ability to control the production and to cause the absorption of specific adventitious tissue deposited in the nervous system to be as marked as in any other part of the organism, but we have no control of the base tissue which the normal process of repair bring to fill the gap left by the breaking down and absorption of the specific new growth. The inherent tendency for scar tissue to contract cannot be controlled. In the grosser structures of the body this behavior of scar tissue matters little, but in the delicate structures of the nervous system this scar may cause as much or more irritation than the specific neoplasm itself. Hence paralysis, loss of function, irritative lesions, etc., which ensue as a result of such secondary process are as liable to be lasting as from any other pathological cause.

*Syphilitic apoplexies are seldom rapidly fatal, and are less liable to be followed by permanent injury.*

The principal reason for this favorable view is that the great majority of the specific brain lesions are rather slowly developed, consist of specific tissue over which we have marked therapeutic control.

Gowers and most authorities give good prognoses in cerebral apoplexies, as regards immediate danger to life in the first attack, but declare the danger to be much increased by succeeding ones. In syphilitic apoplexies this does not obtain, as we observe repeated attacks and oftentimes final and complete recovery.

*The lesions of the nervous system produced by syphilis in the secondary or blood stage of the disease are far more remedial than the late lesions.*

While there are acknowledged exceptions to this proposition, and clinicians sometimes get brilliant results from proper treatment of late lesions, yet with far greater frequency are left to reflect upon what Joseph Collins terms the "powerlessness of therapy in the tertiary stage." The cause of this wide difference in the responsiveness to treatment of the early and late lesions is not far to seek. In the early lesions the new tissue partakes of the character of the specific neoplastic material which infiltrates the capillaries of the neuroglia, or the capillaries of the blood vessels, over which tissue we have marked therapeutic control. But in the

late lesions the process has been more insidious, and the tunica intima of the arteries have been infiltrated by the specific products to a point of partial or total obliteration of their lumen, with a gradual cutting off of the nutrient supply of the neurons. It is not hard to conceive that the starved nerve cells shrivel up and cease function, one after another, until the limit is reached, when the remaining ones can no longer compensate for their disabled fellows. This is usually the time when the patient is brought to the neurologist, with an atypical, widely varying set of degenerations to receive a comparatively hopeless prognosis.

*To the specific endarteritis we must look for the principal cause of syphilis of the large ganglia.* This is because the specific endarteritis is specially prone to attack the branches of the middle cerebral artery. Here in the internal capsule a small lesion whether due to hemorrhage or a localized softening, may give rise to widespread and permanent palsies. Lesions affecting this portion of the brain are very liable to resemble ordinary apoplexy, and have the same prognosis.

Thrombosis is by far the most frequent lesion met with as a result of the specific endarteritis; hence the gradual occlusion of the artery is accompanied by a slow onset of the apoplectic symptoms, as Sachis says, "It is not as apoplexy in the good old sense of the word, where the victim is 'struck down' as by an unseen hand." The resulting hemiplegia is often irregular and incomplete. Such a paralysis may be as lasting as that due to other disease, but in many instances recovery is rapid and complete. Buzzard (Clin. Lectures on Disease of the Nervous System, London, 1892) details the case of a man who after a specific hemiplegia lay quiet and somnolent one month, and then so far recovered as to win a rowing match on the Thames. Whether the thrombus becomes canalized or recession of the bulging arterial coat occurs, or collateral circulation does its duty more fully, possibly because it has been prepared for the emergency by the gradual onset of the actual accident, is difficult to state; but certain it is that acute softening and hence permanent loss of function is less liable to supervene when such accident is due to syphilis than from other causes.

Our foreign friends, led by Dr. Gowers, take a very pessimistic view of the curability of these lesions. I believe the cause of this pessimism lies in the therapy of the European specialists. When Gowers delivered his famous lectures on Syphilis of the Nervous System, the English physicians had not recognized the wonderful effects to be gained by the massive doses of the iodides,



which the Americans vainly advised them to administer. In fact, European physicians consider one to three drachms a day of kali-iodide to be heroic medication.

*Prognosis of syphilis of the convexity is usually good.* The prodromata are usually so marked as to demand early treatment, which is the salvation of these cases. The sudden or gradually developed attacks of coma, slight and transient palsies or somnolent conditions are usually the result of localized congestions or anæmia, and are not always, even if long continued, of bad import.

I have the notes of a man with an incomplete syphilitic hemiplegia, who so far recovered as to be able to be at his office and with little aid accomplish a considerable amount of work. But it was noticed that he had staring spells and peculiar "absences," from which he would suddenly arouse and for a time renew his work with a feverish energy, only to relapse into his former condition. He refused treatment, and for six months continued in this state, which finally culminated in several severe epileptic convulsions. Treatment was resumed and pushed, and he recovered, but with considerable loss of memory. He has remained well for seven years.

*In the localized convulsive seizures which are usually termed Jacksonian epilepsy, the prognosis is usually good.* The following case, which I saw with Dr. Brokaw, is illustrative:

Complete hemispasm of left side of young married woman, with a distinct history of specific infection eight years previous. Signal symptoms begin in great toe, extending successively to leg, thigh, trunk, forearm and hand; lastly to neck and face until the whole left half of the body was in active clonic spasm, which lasted about one minute, leaving a typical functional palsy, which disappeared in about six hours. Attack was frequently followed by aphasia and always by severe headache. She had over seventy-five attacks. Specific treatment made a complete cure in the case, six years having passed with no return, although she has had no treatment in five years.

744 Prospect street.

## CASES ILLUSTRATING THE EFFICACY OF HYDROTHERAPEUTIC MEASURES.

BY CHRISTIAN SIHLER, M. D., CLEVELAND.

Case I. A rather fat woman having had an apoplectic stroke two weeks previously, who was paralyzed on one side, was brought to the Lutheran hospital. She had a good-sized bed sore, and her mental condition was very much disturbed. She was particularly troublesome at night, could not sleep and made so much noise that the people on the street would be attracted by it. She at such times showed positively vicious propensities, promising the nurse that she would muss the bed, which promise she faithfully carried out.

I tried all the drugs at my command; some of them proved useless and others seemed to make her worse.

On account of her weight I had hesitated to use baths, but finally was compelled to do so.

I ordered her to be placed into a tub of warm water, 96 to 98 degrees, and to have cool water of 70 degrees gently poured over her head continually while in the bath, where she was to remain 30 minutes. The effect was remarkable. She slept the first night from 11 to 4 o'clock, and the second night even longer, and furthermore she was able to use her hand and forearm after the second bath.

As this bath can be given at home I will add that a very convenient manner of applying the cold water is to fill a rubber sack used for enemas and to let the water flow from this through the rubber tube over the head of the patient. By the regulation of the height of the fall of the water the force of the stream can very accurately be regulated.

The patient herself, recognizing the marked effects of the bath, could not believe that water alone could have such remarkable effects and expressed her belief that something else was added to produce such results. She reasoned like the people who go to Green Springs who all generally give the whole credit to the little sulphur which, I believe, that water contains.

Case II. In December some years ago I was called in consultation to see a patient of Dr. L. in the country. The patient, a hard working farmer, had been ailing since August, complaining principally of insomnia and pains in different parts of the body. When I saw him he had an attack of dysentery and had some fever, but this was only an accidental complication. His

psychical condition was one of lethargy and stupidity. He would begin a sentence, talking very slowly, and before he could finish he had forgotten what he was talking about. He was restless, took his pillow and went from bed to couch. Watching him I found that over different parts of the body small bundles of muscle would contract, which fact rather alarmed me, as it led me to suspect some organic change in the brain.

All medicine had proved very inefficient and none had been able to produce anything like satisfactory sleep.

I told the attending physician frankly that I did not understand the case, but at any rate we ought to try to procure sleep for the poor devil.

I suggested three warm baths a day of one-half hour duration, with two pails of cool water to be poured over his head gently in small quantities at a time. I had my doubts that I could do anything for the man and was pleasantly surprised when I heard through his relatives the following spring that he had fully recovered, that even after the first bath he had slept an hour and that the duration of the sleep had increased from day to day while the treatment was continued.

I then also learned that the man had even not allowed himself enough sleep, but had gone to his work at four o'clock in the morning after sleeping perhaps four or five hours.

This overtaking of his brain explained to me his whole case and the beneficial effect of the treatment.

The drug-sleep is of course better than none at all, but only that produced by baths can really be looked upon as entirely beneficial. This case was treated at home, and I would earnestly recommend similar treatment to my colleagues.

I could relate still another case, where a man recovering from pneumonia, where the insomnia and delirium would not yield to any drug, was promptly benefitted by this same kind of bath.

Case III. While the two cases just described were suitable for home treatment, the third one was of such a nature that only in an institute, where the necessary apparatus and a good nurse were at the disposition of the physician, could such favorable results be obtained.

The patient, a healthy, strong laborer, had had one of his legs injured in a trench by falling earth. The injury was made more severe by the circumstance that one side of the leg was pressed against a plank, making the bruising of the parts more severe.



The patient had been under good medical care, was treated in a hospital. Rest, plaster-paris and liniments had been used, and the best surgical talent of Cleveland had been consulted. The limb, however, had not changed very much for the better for about a year.

When I saw the patient the limb was painful and swollen—no bones had been broken—and had an unnatural feeling as though it was infiltrated with a semi-solid exudate. The skin was red and glossy over a large part, and had that appearance which we see in parts where the nerves have sustained considerable injury.

I must say that I had my doubts if anything could be done, but told his employers, who brought him to me, that I would give the water treatment and massage a trial.

The patient came to our institute three times a week for about three months, and later twice and once a week. After about four months' of treatment I could not see any difference in the appearance of the two legs. The injured member had become almost painless, had the feel of the sound limb and the patient had been walking without a cane and doing work.

This case illustrates that even almost hopeless-looking cases can derive some benefit by patient and judicious treatment.

The treatment was as follows: The limb was placed in a sweating oven for fifteen or twenty minutes; then massage was used, at first very gently, then the Scotch douche, i. e., alternating hot and cold jets of water thrown on the parts.

To the surgeons I would say, let me have such crumbs that fall from your table.

Looking for a rationale to explain the improvement brought about by the hydriatic procedures. The warm bath will invite the blood away from the brain to the body and the skin and the cool affusions will tone up the overdilated vessels of the brain. In the first patient undoubtedly the laceration of the brain tissue did set up a reactive hyperæmia of the rest of the brain, which being relieved the patient could sleep, and perhaps the congested nerve-centers in the neighborhood of the injury were able to perform their function.

In the second case the nerve-centres which had expended energy beyond their normal limit and were half starved, were enabled to feed during the sleep and thus gradually to recuperate.

In the third case I suppose a solid and semi-solid exudate had blocked the lymph spaces, which nature was unable to remove. The actual mechanical aid and the stimulation of the water treat-

ment removed this substance and also increased the nutritive powers of the capillaries, a function which I think these structures carry out.

Some years ago I visited the gynæcological clinic of a medical school in another state. The professor first removed a myoma from one patient (wherefore I praised him in my mind), and then brought in another patient in whom a defective perinæum and lacerated cervix were found and an operation decided upon. For this I did not praise the professor in my mind. The good woman had had these tears, etc., for years and years, and they gave her no trouble. Why should they be the cause of her present complaints? Her complaints, furthermore, were only such as pointed to a pathological condition in her nervous system.

But she had fallen into the *hands* of the gynæcologist and the treatment was that of the *hand*, not the brain of the professor.

What that woman wanted was a three months' rest at a pleasant health resort, baths, massage, music, to have a vacation—perhaps some bromides to help along.

And yet the operation may have done her some good. Besides the operation such a patient gets perhaps the only three months' rest she ever had. She gets the attention of her family and of a celebrated professor, who assures her that she will get well and who can assure her that the operation is not attended with danger.

After the operation she is not allowed to work so hard for some time, etc., and if the professor has made an impression on her she will half believe herself into a better condition. Yet I think that my advice would have been the more pleasant and the better one.

I have lately looked into Herman's work on gynæcology and was very glad to see that opinions which I have had concerning a class of gynæcological cases were held by this authority, who is an operator par excellence. He argues that many of those cases of uterine inflammation treated by the gynæcologist were really only nervous cases that had become uterine by the efforts of the doctor, who had drawn the attention of these patients to their womb and who very often made the patients worse instead of better. He says what these patients need is treatment directed to their general health. But curiously he has not a word to say about the usefulness of water—does not mention it. We have here the same attitude towards water that the English medical profession has taken towards the Brand method of treating typhoid fever.

And yet even from the short experience I have had with water in treating these women whose nervous system has experienced a break down, especially near the climacteric period, I am convinced that without water the treatment of such cases must be very unsatisfactory; while having used it for some weeks only, patients assert that for years they have not felt as well.

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## REPORT OF A CASE OF OVARIAN CYST WITH TWISTED PEDICLE.\*

BY FRANK E. BUNTS, M. D., OF CLEVELAND.

Patient, 39 years of age, white, married, born in the United States, was admitted to Charity Hospital Jan. 12, 1900.

Personal History: She has borne two children, youngest being now 11 years old. No history of any miscarriage or other abnormal condition relative to the genital organs. Examination of the urine showed some albumen to be present, with hyaline casts. Patient complained of some enlargement of the abdomen which had existed for some time, just how long she did not know. It had never been noticed by her physician. She claimed never to have missed recently any menstrual period, although the last two or three have been very slight. On Jan. 1 she had a menstrual period during which time she caught cold and has been suffering more or less ever since. Following this, up to Jan. 7th, she complained of occasional short pains of a paroxysmal character. On Jan. 7th was taken with a very severe attack which the patient deemed to be cholera morbus. The pains at the time were almost beyond endurance. This severe attack was followed by a clammy perspiration. After this the abdomen was perceptibly enlarged. A physician was called who recommended cold applications and high enemas, thinking that her trouble was peritonitis. She complained of being worse, suffering pain and vomiting occasionally. Friday night, Jan. 12, was brought to the hospital. From the time of the attack of colic she was not able to retain anything on her stomach, even water being rejected, the vomited material being of a brownish gray color and of a fecal odor. This latter was not corroborated by her attending physician, who had noticed no fecal odor to it, nor was there during the time she was at the hospital any perceptible odor of this character. When first seen she was suffering from great thirst and was constantly moistening her lips

\*Reported before the Cuyahoga County Medical Society, March 1, 1900.



to relieve the dryness, the water being vomited as soon as swallowed. The patient had a very weak pulse, rate being 130, respiration being increased. Her mental condition was fairly active, though her statements did not seem to be thoroughly reliable, restless, tossing about and at times incoherency of thought, constantly feeling as though her bowels were about to move, but never having a movement. Temperature varied from 105 to 103. Twenty-four hours after entering the hospital and six days following the acute attack the pulse began to grow suddenly very faint, small volume, arrhythmic, irregular. Breathing became shallow, rapid, varied from 40 to 50 per minute. Cold perspiration made its appearance. Thirst was intense, and shortly the patient rapidly sank and at 10 p. m. died.

I did not see the patient until the afternoon of the day that she died. At that time she had a large, apparently solid mass in the median line, easily palpable through the abdominal wall as well as vagina. The extreme shock from which the patient seemed to be suffering suggested a ruptured extra-uterine pregnancy. A large mass in the median line being indistinguishable from the fundus of the uterus, which could not be palpated, made the possibility of a fibroid tumor suggest itself. The impossibility of securing movement of the bowels made it probable that this tumor was pressing upon the intestines and thus mechanically interfering with the emptying of the gut. The condition having existed for something over five days, I thought the patient would stand as much of a chance if I waited until I could get word from the physician who had seen the patient regarding previous history of which we had thus far had practically nothing. It was late in the afternoon before I succeeded in reaching him by telephone and he then stated that he had not noticed the mass but considered it to be a case of peritonitis. A few hours afterward I received word from the hospital by 'phone that the patient was in a collapse and she died in a short time.

Autopsy. Upon opening the abdomen a mass partially covered with intestines was revealed. This mass occupied a central position and appeared to be a cyst of the left side. Intestines were perfectly normal no inflammatory process having taken place, either above the point of constriction or below. The portion of gut below the tumor was extremely pale and distended with gas. The cause of the obstruction of the bowels was not due either to adhesions or constriction, but to the pressure of the tumor posteriorly against the intestines. A considerable amount of blood clot was

found in the abdomen. A portion of the intestines below the tumor was collapsed. Repeated enemas had been given, but failed to produce a movement of the bowels. No other diseased condition was found in the abdominal or pelvic cavity.

The main points of interest which have caused me to report the case were the diagnosis that was not made and the question as to what might have been accomplished by operation. Certainly it seems that if a diagnosis had been made early enough, the life of the patient might have been saved, and the cause of the illness removed. The tumor was exactly in the median line, and felt as though it might be a pregnancy. It was impossible to locate the fundus because it lay back of the tumor. The points which came up in the diagnosis were extra-uterine pregnancy, or a pregnant uterus, or fibroid tumor. I must confess that the question of twisted pedicle never suggested itself to me. The slight checking of the menses, the collapse mentioned previous to her coming to the hospital, the history of pain, all made it look like a rupture in tubal pregnancy, and that it could be a twisted pedicle did not appeal to me. The case had waited five days, and it did not seem that any greater danger could arise by waiting a few hours longer. That it was a pregnancy of the uterus I did not believe, for the history of slight menses, and the appearance of the case did not warrant such a conclusion, nor was there anything that indicated it except some slight softening of the mouth of the uterus. In the light of after events I was of course very sorry that I did not operate, but at the time it was practically impossible. As to fecal vomiting, there was none at that time. The physician assures me that he saw what was vomited at the time of the attack, and that though the family claimed it was fecal, yet he assures me positively that it was not of that character at all. As to a diagnosis of obstruction of the intestine, I felt that that also could wait since it had gone safely so long. Death was probably due to the septic condition, owing to the escape of the fluid through the sac. There is a little fluid in it now of a heavy character. I think it is characteristic of these cysts that those on the left side twist from right to left and vice versa. Its position of rest upon the uterus gave it the large, hard feeling of a fibroid. The case is of value as calling to mind the necessity of having this condition in mind in making an examination.

#### DISCUSSION OF DR. BUNTS' PAPER.

*Dr. Lower:* Was there much peritonitis in this case?

*Dr. Bunts:* No, there did not seem to be any severe peritonitis.

*Dr. Lower:* Was there much obstruction of the bowel, or any evidence of a septic condition resulting from it?

*Dr. Bunts:* Only the obstruction due to pressure of the tumor, and why she should have had a temperature of 105 degrees I do not know.

*Dr. Stuart:* It is interesting as a matter of diagnosis to know what symptoms the man who first saw the case, who saw it in its early stages, was able to find, what temperature there was, and whether he first thought it to be peritonitis.

*Dr. Chadwick:* Supposing that a diagnosis could have been made in the early stages, would it have been possible to restore the pedicle to its normal position by manipulation?

*Dr. Bunts:* Yes, perhaps, provided one could tell which side the pedicle was turned towards. There was no way of deciding even if we had known what the difficulty was, and the pedicle might have only been still further twisted by manipulation.

*Dr. Foote:* Was there any history of enlargement?

*Dr. Bunts:* No, and the first physician could give no history of it, either.

*Dr. Lower:* It seems strange that there should have been such a septic condition.

*Dr. Bunts:* Some clots had escaped into the abdomen, and while no culture was made from them, they might have been septic.

*Dr. Tuckerman:* On autopsy did there prove to be any ascitic fluid?

*Dr. Bunts:* No.

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## OPERATION FOR PERFORATED TYPHOID ULCER EIGHTEEN HOURS AFTER PERFORATION.

BY WILLIAM E. LOWER, M. D., CLEVELAND.

Assistant Surgeon to St. Alexis Hospital; Attending Surgeon to Luthern Hospital.

The object in reporting this case is to aid in furnishing complete statistics in operations for typhoid perforation. Probably an earlier operation might have saved this case.

Mrs. M., aged about 28, married, American. Family history, negative. Personal history good. After some prodromal symptoms the patient was sent to bed three weeks ago with the usual symptoms of typhoid. For two weeks she ran a temperature



ranging from 101 to 104 with a pulse from 106 to 120. At the beginning of the third week she had a severe hemorrhage, which was controlled by opiates. One week later, or at the end of the third week of the attack, she complained of sudden severe pain in right iliac region. There was no drop in temperature, which registered 104½. The pulse became very rapid, small and thready at 160. Respirations 32. The abdomen was not much distended, but there was a board-like rigidity and some tenderness. Patient was in collapse. The skin was moist and had a bluish tinge. Tongue dry and coated. There was an evident vaso-motor break down. The bowels had been constipated since the hemorrhage one week before. The spleen was enlarged and palpable one finger's breadth below costal margin. A diagnosis of perforation was made, the perforation having occurred at 3:15 p. m. At 8:30 the following morning I saw the case in consultation with Drs. Lewis and Knowlton and we decided upon the operation. About 18 hours after the perforation the patient was anæsthetized and the abdomen opened by an incision about three-fourths of an inch to the right of the median line. Large quantities of fecal matter were found free in the peritoneal cavity. About 14 inches from the ileo-cæcal valve a perforating ulcer was found. The perforation was about the size of a goose quill, with an area of induration around it. The ulcer was turned in and the peritoneal surface coated over it by a double row of silk Lembert stitches. No other points of leakage could be determined. The abdomen was flushed out with large quantities of sterile water. The wound was drained with strips of gauze. The patient was on the table 20 minutes for operation. Normal saline solution was given into the breast and per rectum. Patient placed in bed with hot water bottles about her, strychnine given, and the foot of the bed elevated. Six hours later the pulse was 120 and the respirations 28. She continued to improve and at the end of 12 hours the pulse was 118 and of good volume.

The patient lived 60 hours after operation, had several quite free movements of the bowels, and died no doubt of sepsis or of a general peritonitis. Dr. Pautau says about 33 per cent. recover if operated upon.

#### DISCUSSION.

*Dr. Tuckerman:* That is if operated after eight hours. Keen says the same.

*Dr. Lower:* In this case the attack began at 3:15 p. m. They could not get their physician for three hours, during which time

the patient was suffering much pain. By the time he reached the case and a consultation was held it was so late that it was considered best to postpone the operation until the next day. Operations performed after the first eight hours may be the most successful of any in certain cases and under certain conditions of shock, but it does seem logical that the longer cases of a septic infection are allowed to continue without intervention, the less are the chances for recovery. The contents of the bowel was pouring freely from the ulcer when I found the opening, and that would hardly be the per cent. of recovery in such cases as this. The general peritoneal cavity was already infected. This is the second case that I have operated, the first case living six hours after operation. This case was operated on the third day after perforation, when general peritonitis was very marked and the patient almost pulseless. This was a case of ambulating typhoid. He had not been confined to bed at any time of his illness. Shortly after drinking a glass of cold water he was taken with a sharp pain in right side and immediately went into collapse. When the physician saw him his temperature was 105. In this case, however, I did not suspect typhoid ulcer. This case was seen in consultation with Dr. Yarian and will be written up more fully at a later time.

*Dr. Bunts:* I was present some time since at an operation for a like cause upon a man at the Lakeside Hospital. It was but a few hours after perforation, it having occurred fortunately while the attending and visiting physicians were both in the hospital, and an attempt to save the life of the patient was made as soon as possible. The perforation was found very quickly, the operation being done under cocaine. The opening was closed by Lembert sutures, and the cavity irrigated. The patient died in two and a half days. The patient was in a bad condition at the time of operation, so that it was not a very hopeful case—somewhat cyanotic and a pulse of 130.

*"The Osborn."*

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## Abstracts and Extracts.

The time is near at hand when the family or the individual will not wait until they are seriously ill before sending for their physician, but will carefully and thoughtfully select their medical adviser, not on account of his attractive personality, his prominence in church and secret societies, not because he is a trimmer

and willing to walk their particular chalk-line, but for the reason that he is physically, mentally and professionally well endowed, that knows his business. After selecting such a one he will be truly their medical counselor, and they will call upon him at regular intervals during the year to make proper examinations and take stock physically, as it were, and direct their habits of life to conserve their best health. As the intelligent and conscientious attorney now has charge of his client's legal affairs to help him to avoid litigation and keep him *out* of court, so will the medical counselor of the future guard his patients, help them to maintain health, conduct them along the lines of their physical well-being, so that they can do their best work and live long, useful lives, demonstrating in their results the truth that every individual born into the world, if properly looked after, should be a useful citizen of the State for not less than one hundred years.—*Dr. I. N. Love in St. Louis Mirror.*

As a pure sleep-producer I know of no drug equal to the hydrate of chloral, and, singularly, although all my life I have heard of the chloral habit and of chloral dependence, I have never encountered a case of it—I have never known its use to create a craving, or its withdrawal, when the nervous system was restored to the point to permit it, to be followed by sleeplessness attributable to the withdrawal. Its use is open to objection where there is feebleness of the heart, but even in such cases, where this is not extreme, its effects are happy, and cardiac depression can frequently be counteracted by the use of quinine. A fifteen or twenty-grain dose is as large as is well to prescribe. Sometimes to this a few minims of fluid extract of hyoscyamus, or a teaspoonful of elixir valerianate of ammonia, may be added, or the bromidia may be substituted.

Sulfonal and trional are also excellent sleep-producers, and in some cases supply a want that chloral does not meet. In neurasthenic states, and in agitated melancholia, they are especially useful. Their good effect wears out, however, and they are not well suited to nightly administration for any length of time. They are best given in hot milk.—*C. B. Burr, M. D., in the Indiana Medical Journal.*

I would especially urge against the giving to young children of drugs whose chief therapeutic action is to suppress the convulsive phenomena only. We ought not to be satisfied with this, for in administering such drugs there is danger of masking what may



be valuable objective indications of the disease, and experience teaches that we shall largely destroy the digestive and assimilative functions of the child, something we should guard against above all else. Were I to tell you the number of cases I have seen that have gone for years on a routine suppressive treatment, the bromide of potassium being the favorite drug for this purpose, and how it destroyed the digestive and assimilative functions of the patient, I might tempt credulity further than would be wise.

If a stream of water was flowing from the end of an iron pipe and we attempted to stop its flow with a plug of earth, we might succeed for a time, depending on the water pressure; finally the water would break forth again in greater volume and do more damage than ever. The true way to have stopped the flow would have been to cut off the source. The same principle applies in the use of the bromide of potassium in epilepsy. I am frank to say that I have yet failed to see a case in which the use of this drug cured the disease. I have seen many cases in which the fits were suppressed for months at a time, but the administration of the drug had to be continuous and in large doses to do this; immediately the drug was withdrawn the convulsions returned.—*William P. Spratling, M. D., in Medicine on "The Curability of Epilepsy."*

In an article on "Carbolic Acid and its Antidotes" in *Merck's Archives*, alcohol is stated to be the best antidote known, and to emphasize his statement the author quotes a case of carbolic acid poisoning treated in this way. The report is as follows: The patient, a woman, aged 36, had taken the acid with suicidal intent. One pint of alcohol was poured down her throat immediately, followed soon after by a pint of milk. After this whisky was given hypodermically, and alcohol and whisky by the mouth at intervals of half an hour and less. In three hours and twenty minutes she had given off 20 fl. oz. of alcohol and 18 fl. oz. of whisky without showing any signs of alcoholism. The whisky was substituted for alcohol because the supply of the latter on hand had given out. There were very few signs of shock, and in two weeks the patient was discharged. This case seems to indicate that not only does the alcohol render the carbolic acid harmless, but the carbolic acid also neutralizes the toxic action of the alcohol, as is said to be the case in antidoting snake venom with alcohol.

The following is part of the proceedings of the section on Orthopædic Surgery, New York Academy of Medicine, at the February meeting:

## LATERAL CURVATURE THE RESULT OF INFANTILE PARALYSIS.

Dr. Townsend presented a boy, 5 years old, who had worn Plaster of Paris jackets for three years for weakness and deformity of the spine. When first seen he could not stand or sit erect, from disability of the muscles of the back, evidently the result of infantile paralysis. When presented, he was able to hold himself up without the jacket. Rotation was very evident in prominence of the angles of the ribs on the left side and flattening of the chest wall in front on the right side.

Dr. V. P. Gibney found that the left side measured from the centre of the chest to the spinous processes 9 inches, the right  $8\frac{1}{2}$  inches.

Dr. Judson found that the left arm measured  $6\frac{1}{8}$  inches in circumference, the right 7 inches, supporting the diagnosis of infantile paralysis. He said that as rotation produced not only prominence of the angles of the ribs, but also of the left scapula the curve was to the left and included a large part of the column with but little if any compensating curve. These marked prominences showed extreme degree of curvature in the bodies of the vertebrae coincident with slight curvature in the spinous processes.

Dr. Myers said that in these extreme cases regular exercises should be given to promote development of the muscles, specially those of respiration and apparatus should be designed in such a way as to reduce restriction of the trunk to the lowest point compatible with the required support.

Dr. Sayre said that his experience with similar cases led him to rely for necessary support on apparatus that went all the way around the child, in order to prevent a great increase in deformity. In the case of the patient presented, he thought benefit would be gained by having the support go higher and take in the head. Although the plaster jacket might be heavy the child would be able to do hard work in it and was more comfortable than with apparatus constructed of wood, leather, silicate or any other material so applied as not to extend all the way around. In suitable cases regular systematic exercises would develop the muscles and prevent the ill effects which might come from undue restriction.

Dr. Townsend said that the proper application of a restricting brace to a growing child was not an easy thing, especially as the parents, in the absence of urgent symptoms, would not bring the child oftener than once in three or four months. As the patient was gaining strength, he believed that in time the treatment should include regular exercises.

## DOUBLE LESIONS OF THE KNEE IN CHILDREN.

Dr. Taylor presented a girl, 18 months old, who had suffered since July, 1899, with what appeared to be rheumatoid arthritis of both knees, which had been swollen and stiff and tender. They were flexible considerably beyond 90 degrees, but were limited in extension, the left to 120 degrees and the right to 130 degrees. Two of the finger joints were similarly affected. A rheumatic or specific family history had not been found.

He also presented a girl, 6 years of age. Two months ago, without known cause, heat and swelling had appeared in both knees. When first seen, on January 29, 1900, there was effusion with heat, pain and swelling and the child walked with some difficulty, especially after sitting for a while. The knees were extensible to 180 degrees and flexible a little beyond 90 degrees. Each measured  $10\frac{5}{8}$  inches. Pathologically the family history had been uneventful and specific indications had not been found. Treatment by mercurial inunctions had been followed by reduction of the swollen knees to  $10\frac{1}{2}$  inches and improvement in every other particular.

A positive diagnosis had not been made in either case. Double knee lesions in young children were rare. While specific joint lesions were not often seen in children, he thought that the absence of a clear syphilitic history in parent and child did not necessarily exclude infection.

Dr. R. A. Hibbs said that the inflammatory condition present indicated the application of immobilizing apparatus.

Dr. Judson said that the sub-acute character of the inflammation called for protection of the joint from the weight of the body. In a case in which a single member was affected the limb could be made pendent by an apparatus which would throw the burden on the unaffected limb, but when both the knees were inflamed this mechanical resort failed. He suggested that standing and locomotion be avoided so far as it could be done, with the expectation that the ultimate result would be favorable through general treatment and healthy growth.

Dr. G. R. Elliott said that the bilateral involvement argued constitutional infection and that the facies and the peculiar conical appearance of the fingers which narrowed down to a point, with an enlargement that did not belong wholly to the joint, indicated syphilis rather than rheumatoid arthritis.

Dr. Sayre said that the possibility of syphilis was suggested by the facial appearance and expression of the baby and by the



presence of phalangeal periostitis. He favored experimental anti-syphilitic treatment.

Dr. Myers said that rheumatoid arthritis was unusual so early in life, and in adults a long period of rigidity and pain generally preceded the appearance of swelling of the larger joints. He thought that the smaller child was affected with syphilis rather than with rheumatoid arthritis.

Dr. Taylor said that the appearance of the knees and the implication of several finger joints had inclined him to the opinion that it was a case of rheumatoid arthritis which, although rare, was not unknown at this early age. If inunctions and cod liver oil internally produced no good effect anti-syphilitic medication would be tried.

#### TRANSPLANTATION OF TENDONS.

Dr. Townsend presented a boy, 14 years old, on whom he had operated for the relief of disability of the hand accompanying right hemiplegia, the result of cerebral palsy in infancy. The right heel cord had been cut several years before. He had never had useful control of the right hand, which was a typical claw hand. The fingers were flexed on the palm, with a slight ability to extend, and the hand was sharply flexed so that its dorsum was nearly at a right angle with the fore-arm, with no ability to extend the wrist. The fingers had no power to grasp on account of the position in which the hand was held. The object of the operation was to correct the flexion at the wrist and restore the power of grasping to the fingers, by shortening the extensor tendons and attaching to them the cut ends of certain flexor tendons passed through the space between the radius and ulna.

On Dec. 21, 1899, through an incision on the flexor surface of the wrist, the tendons of the flexor carpi radialis, the flexor carpi ulnaris and the palmaris longus were divided by scissors just above the annular ligament and silk threads were stitched to the ends to prevent their withdrawal upward out of reach. The tendon of the extensor communis digitorum was then exposed about  $1\frac{1}{2}$  inches above the wrist by an incision on the dorsal surface. It was folded on itself twice, to shorten it, and between the folds the cut ends of the flexor tendons, passed through from the flexor surface, were attached by catgut stitches. The wounds healed per primam, except at one little spot which closed in ten days. The fingers were kept extended in splints for six weeks to insure union of the tendons. The result had been a hand held perfectly straight in a position of extension with power to extend and flex through an arc of about 20 degrees, and the restoration

of a fair grasp to the fingers, a condition subject to probable improvement by use, massage and electricity.

Dr. Gibney said that it would be difficult to prevent adhesion from taking place in the interosseous space, and even if the tendons did not adhere they might be so constructed as to interfere with the action of the muscles. In an operation already planned he would try to make the space larger by a series of sutures through and through, making the opening large enough so that there would be no binding of the tendon. With large push needles, such as were used for deep sinuses, he believed he could push the needle through the tissues from the other side, back and forth, and get a large enough space to pass the tendons through very easily.

Dr. Elliott said that the result was excellent. He believed, however, that the gain was one chiefly by improved position, due to the folds which had been made in the extensor communis tendon, thereby taking up the slack. Cutting off the three tendons and passing them through between the bones simply had transferred their flexor points of attachment to the cicatrix. They had already grown fast. The same result, or better, would have been accomplished by simply cutting the three tendons, thus getting them away from the wrist and allowing them to re-attach themselves as in retreating tenotomies on the eyes.

Dr. Myers had noticed that extension of the wrist was caused, at least in part, by the voluntary action of the extensors. Holding the boy's arm he had felt contraction of the extensors accompanying an effort to extend the wrist. The shortening of the extensor communis would give the other muscles a chance to recuperate.

Dr. Gibney said that when the electrode was placed over the flexor muscle the action was on the cicatrix, there was no extension of the wrist.

Dr. Myers said that a return of voluntary motion sometimes preceded return of the faradic reaction.

Dr. Townsend said that the application of electrodes to the flexor carpi ulnaris produced contraction below the scar on the extensor side. The boy had already acquired control of a pen and was learning to write and anxious to use the hand all the time. The progress of the case would tell whether the possibility of adhesion of the tendons would be a real or fanciful difficulty.

Dr. Gibney said that in some recent operations the tendons had not been transplanted but simply shortened by taking loops in

them. The result had been a little increase in power and the hands had been prevented from going over so far in flexion. He thought that operations on tendons promised a great deal in old hemiplegias and hemispastics.

Dr. Judson said that they would be more likely to achieve permanent improvement in the upper than in the lower extremity. In the latter the great strains incident to locomotion would make ultimate success uncertain.

TIBIAL OSTEO-SARCOMA MISTAKEN FOR A SLIPPING CARTILAGE.

Dr. Gibney presented a specimen derived from amputation at the lower part of the thigh. The patient, a woman 26 years of age, when walking down a hill in July, 1898, had inadvertently turned her foot outward with resulting very acute pain, lasting 15 or 20 minutes, over the internal semi-lunar cartilage of the knee and inability to straighten the limb for several minutes. Disability in bed for two or three days was followed by persistent weakness and more or less pain in the limb. Several recurrences of this "giving way" of the limb, with increase of disability had led to the application of Plaster of Paris bandages in the fall.

In the spring of 1899, when the patient was seen for the first time, she was soon enabled to walk much better by the application, on April 6, 1899, of a brace which was adjusted at first to permit, and afterwards to prevent, motion at the knee. Pain and tenderness were combated by sinapisms and the cautery. Removing the brace without permission, she fell with another painful "giving way" of the limb. She left the city June 20, 1899, carefully instructed in the management of the brace. Pain and disability persisted, however, and increased during her prolonged absence, and when she was again examined on January 29, 1900, considerable enlargement was found over the head of the tibia with no distention of the synovial sac. Up to that date the trouble was believed to depend on laceration of the internal semi-lunar cartilage with a wrenching of its attachments, the prominent features of the case having been: Repeated sudden arrest of locomotion from slight injury in which the foot was twisted, pain at the internal tibial tuberosity, later a thigh and calf measuring  $1\frac{1}{2}$  in. and  $\frac{1}{2}$  in. less in circumference than those of the unaffected limb, considerable reflex spasm, absence of heat, a freely movable patella and diminution of pain and increase of ability following the application of a brace. On Feb. 25, 1900, when the healing of the surface which had been blistered permitted a better examination, a small and painful indurated mass was discovered, which



was incised on Feb. 10 and found to be an irregular whitish tumor over the tuberosity of the tibia and encroaching on the joint. The underlying bone was softened. A second tumor of grayish material with haemorrhagic spots, was found near the first and to the outer side of the tibia. The examiner reported round-celled sarcoma with some spindle cells, and even giant cells, and amputation was done on Feb. 15 about 3 inches above the condyles.

Dr. Elliott recalled a similar case, reported by him at the meeting of the Section held on Oct. 20, 1899, in which a correct diagnosis had been overlooked, although severe pain had been entirely unaffected by fixation and traction persistently applied for tubercular joint.

Dr. Townsend, in a case reported at the same meeting, had mistaken a sarcoma for an osteitis of the head of the tibia. In his case, however, pain had been an unimportant feature and the duration of the disease was exceptionally prolonged. He wished to emphasize the difficulty of diagnosis of osteo-sarcoma near the knee before it had reached a point when a distinct tumor was presented.

Dr. Sayre recalled two cases of amputation for osteo-sarcoma of the femur which had for months presented all the appearances of tuberculosis of the knee.

Dr. Judson recalled a case illustrating the reverse, that of a girl, 13 years old, supposed to have some trouble requiring orthopædic treatment of the right knee joint. A competent authority said, however, after repeated examinations that the trouble was probably malignant and advised an anæsthetic for exploratory incision and perhaps radical operation. It was an osteitis of the femur, which recovered with the protection furnished by a Thomas splint, and left no trace except a scar which followed a sinus on the posterior and lower part of the thigh.

Dr. Gibney said that early in the history of his case traction had partially relieved the pain, while in the late stage relief attended extension of the knee to a certain angle. With displaced cartilage the subpatellar bursa was sometimes acutely influenced by pressure. When the patient returned, after her long absence, the deformity caused by the presence of the mass seen in the specimen corrected the diagnosis of lesion of the semi-lunar cartilage and the incision revealed the nature of the affection.

FOLLOWING IS FROM PROCEEDINGS OF SECTION ON OPHTHALMOLOGY,  
COLLEGE OF PHYSICIANS OF PHILADELPHIA,  
FEBRUARY MEETING.

Dr. William Campbell Posey read a paper on "Mental Disturbances after Operations upon the Eye." Twenty-four cases of delirium were reported. In 19 of these the mental symptoms developed after the removal of cataract, in 3 after iridectomy for glaucoma, and in the remaining 2 after extensive wounds of the eye. Three of these cases were in subjects over 80 years of age; 6 over 70 years; 9 over 60 years, and 2 during the 6th decade. The traumatic subjects were much younger.

The delirium appeared during the first 24 hours after the operation in 2, on the second day in 8, on the third day in 6, and on the fourth day in 2. No atropin was used in 6 instances; in 4 others it was not employed until the delirium had manifested itself, and in the others it was instilled at the time of the operation. Its employment did not seem to have any influence whatsoever upon the mental condition. Both eyes were bandaged after the operation in every instance, but the dressing was removed from the unoperated eye in 9 cases as soon as the delirium manifested itself, without giving any appreciable relief to the mental condition.

It was specifically noted in 9 cases that there was absolutely no tendency toward mental derangement. Evidence of previous tendency was present in only 2 senile and in the traumatic cases. All of the eyes made a good recovery except in 2 cases—one of panophthalmitis and one of traumatic irido-cyclitis.

The delirium was of the same character in all, beginning with a mild restlessness which rapidly developed into an active delirium with hallucinations and ideas of persecution, but passing rapidly under control by the proper administration of narcotics; permanent affection of the brain being remarked in not a single instance.

The writer believes that the cause of the delirium is largely psychical, and he agrees with Parinaud that it is due to the preoccupation upon the part of the patients prior to and after the operation. What the other factors are, which in addition to the preoccupation determine the delirium, are as yet unknown. The frequency with which the delirium is encountered should, however, be recognized, and proper treatment, namely, chloral and bromides, be administered at the first indication of its appearance. Removal of the bandage from the unoperated eye and discontinuance of the use of atropin are not advised.

Constant oversight and judicious and tactful nursing are most essential, and rapid amelioration in the mental condition frequently follows the installation of a proper person by the bedside.

*Discussion:* Dr. de Schweinitz said that the most pronounced case he had ever seen occurred in a man aged 59, upon whom he had performed Forster's operation for the artificial ripening of the lens of one eye, and 1 month later extracted the opaque lens. The man had nuclear cataracts, and vision, except in the central portion of the field, was good. He had organic heart disease, and for several years before the operation had considerable family trouble. Both eyes were bandaged after operation. On the second day maniacal delirium developed, followed by dementia lasting for 2 months. Under large doses of nitroglycerin the mental symptoms disappeared and he eventually secured vision of 6-9. Two years later the man returned to have the naturally ripened cataract upon the other eye removed, and begged that he might be allowed to have the good eye unbandaged after operation. This was done, and he made a rapid recovery without mental disturbance. Dr. Zimmerman stated that while resident at Wills Hospital he had seen numerous cases. The custom at that time was to unbandage the sound eye and get the patient out of bed at the earliest possible moment after the onset of mental aberration. Dr. Veasey also reported mental symptoms after 2 cases of operation—one a patient upon whom the rolling operation was performed for granulated lids, and the other a case of senile cataract. In both instances the delirium subsided upon the removal of the bandage from the unoperated eye. On the other hand, Dr. Randall had removed the bandage in order to check delirium in a cataract patient with absolutely no result, the delirium continuing uninterruptedly for 4 or 5 days. Dr. Harlan stated that the delirium had many types and causes, and that no one explanation would be satisfactory for all cases; therefore the treatment must be diversified to meet individual requirements. Dr. Posey referred to a recent article by Dukes, to the effect that the restlessness of old people is due to the gradual age—failing of the scavenger organs, and that it is owing to their incompetence that the blood is not sufficiently depurated, and arterial tension increased. This author believes that the remedies best adapted to calm these individuals are those which relieve the arterial tension, such as nitroglycerin, though he adds that he found erythrol tetranitrate, gr. ss to gr. j, to be even more valuable.



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## Editorial.

J. J. ELWELL.

The subject of this sketch is more familiarly known by his military title than that of attorney at law or doctor of medicine, all of which of right belong to him. The medical profession, as well as the legal and military, may rightly claim Elwell as one of its distinguished members, and we feel it a privilege as well as a duty to do honor to his memory. :



J. J. ELWELL.





John J. Elwell was born in Warren, Ohio, June 22nd, 1820. He attended lectures at Cleveland Medical College, from which institution he graduated in 1846, and then settled in Orwell, Ohio, where he acquired a good practice. Dr. L. B. Tuckerman (at whose birth Dr. Elwell officiated as accoucheur) remembers him as the family physician for many years, and tells us that he bore the reputation of a very skillful and judicious practitioner of the healing art. While still practicing medicine he studied law, and in 1854 was admitted to the bar. About that time he moved to Cleveland and opened a law office. From 1853-55 he was a member of the Ohio State Legislature, and also edited and published the *Western Law Monthly*. He was also a lecturer in the Ohio and Union Law College, and in the Cleveland Medical College. It was during these early years of law practice that Elwell wrote "A Medico-Legal Treatise on Malpractice, Medical Evidence and Insanity, Comprising the Elements of Medical Jurisprudence," the copyright of which bears the date 1859. The author had evidently studied both medicine and law diligently and to the best advantage, for the work was recognized as that of a master, and gave Elwell a wide reputation as an author and as an authority in that branch of learning. William H. Carpenter, M. D., F. R. S., F. G. S., whom we all know about as the great English physiologist and who was at that time Professor of Medical Jurisprudence in the University of London, said of the book: "I know of no instance in which the combination of legal and medical knowledge has been so remarkably shown, as it has in Dr. Elwell's treatment of the subjects he has undertaken." Golden opinions were won from such men as Prof. Frank H. Hamilton, Hon. John McLean, of the Supreme Court of the United States; John Delamater, M. D., L. L. D.; Hon. John F. J. Fithian, New York District Attorney; Prof. Valentine Mott, Dr. Robley Dunelison, Prof. Geo. B. Wood, Judge Ballamy Storer, and the medical and legal journals of that time. The treatise passed through four editions, the last being in 1881. But medicine and law were not the only subjects that occupied Elwell's versatile and active mind. He was also a temperance reformer, and in the times preceding the rebellion, when the great problems of slavery and state rights agitated the country, he became an ardent Abolitionist. Then the war came on, and in August of 1861 Elwell entered the military service. He brought home from the Secretary of War an order to raise the Second Ohio Cavalry, which he helped to organize and equip, as also the Third Ohio Cavalry and Sherman's Brigade.

From the "History of the Cuyahoga County Soldiers' and Sailors' Monument," to which we are indebted for Elwell's military record, we quote the following:

"Early in 1862 he joined General David Hunter and proceeded with him to Port Royal, S. C., and was promoted to chief quartermaster of the department of the South, with the rank of lieutenant colonel. He served in this department two years and participated in all the operations against Charleston under Hunter, Gillmore and other generals. He took a hand in the bloody assault on Fort Wagner on the night of July 18, 1862, where the Union troops were repulsed with the loss of 1,500 men in an hour. General A. C. Voris, who was terribly wounded at the time and carried off the field by General Elwell, in 'Sketches of the War,' published by the Loyal Legion of Ohio, says: 'Colonel J. J. Elwell, a wonderfully brave man, rode clear up to Wagner, cheering on the men to hold the fort. He did on that occasion what I never saw during the war done by a staff officer whose duties did not call him to thus expose himself, and lead troops in the greatest danger, requiring the highest degree of courage.'

"On many occasions he was seen in the midst of the fray, having for the time abandoned his post as quartermaster general and fighting with all the vim and energy of the most valorous. It was his habit to go into battle with his hat off, and as he rushed forward with his long hair flying in the wind he made a picture of eagerness and forgetfulness of self which was an inspiration to the other soldiers.

"General Elwell was brevetted four times during the war for great and gallant services. The last two years of the war he was in charge of the prison camp at Elmira, N. Y., where there were from 12,000 to 15,000 prisoners of war. He was also connected with the cavalry bureau at Washington at this time.

"His medallion stands in the tablet room of the monument among the distinguished generals of Ohio, having been placed there by his associates of the commission without his knowledge for distinguished services, especially at Fort Wagner.

"A medal was presented to General Elwell by General Gillmore, commanding the department of the South, upon which Forts Sumter and Wagner are engraved, appreciative of his gallant services in that famous siege of two years. He was severely injured several times, and narrowly escaped death from yellow fever at Port Royal in 1862."

At the close of the war, General Elwell returned to Cleveland and resumed the practice of law. Of late years he did not often appear in court, devoting himself to real estate. He was at one time member of the School Board, and was always ready and reliable in any duty of citizenship and prompt to champion any cause he considered right. He was made a member of the Soldiers' and Sailors' Monument Commission June 20th, 1884, and was re-elected as one of the five permanent commissioners. He was a devout member of the Methodist church. His wife and four children died before him. He enjoyed a peaceful and serene old age, and died of no particular disease. As he said: "All that ailed him was eighty years." After such a noble life, with an honorable record in three distinct professions, fame as an author, and the respect and love of fellow-citizens and friends who could not die content? All through his life General Elwell retained his interest in the medical profession. With his versatile and vigorous intellect, his enthusiastic temperament and working force, it is more than likely that had he devoted himself exclusively to medicine, he would have won a name of far greater renown in that profession. But he did the work that came before him and did it well, and doubtless was the broader man and the more useful as he was than as he might have been in the medical profession alone. In person, General Elwell was tall and sinewy. The portrait here presented is an excellent likeness as he appeared in late years.

KELLEY.

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### CONCERNING MALPRACTICE.

Fortunate indeed is the physician or surgeon of any standing who has not been confronted by a suit for mal-practice by malicious, unscrupulous, ignorant and ill-advised individuals whose moral instincts stoop at nothing to gain a point or to further a purpose. And the motive prompting them is usually either an excuse to avoid a settlement of the bill or for purely blackmailing purposes.

In Ohio the law gives a surgeon absolutely no protection in such cases.

Any penniless tramp, charity-case or impostor may easily carry a case into court, for the "sharpers" and "quacks" of the legal profession are always ready to "befriend" and solicit such cases on the understanding that there will be no charge unless a verdict is rendered in favor of the plaintiff—either by fair means



or foul. And then they (generously) agree to appropriate half of the damages rewarded.

And the defendant has no redress. He must submit to the inconvenience necessitated by loss of time, expense, undesirable advertising, etc., and trust for justice, not in God, but to the whim, caprice and integrity of a more or less ignorant, oft times impres-sible, and sometimes prejudiced and dishonest jury. Only last February, during the progress of a suit for malpractice in the Common Pleas Court of this county, a jurymen so conducted himself that were he to receive his just deserts he would be sent to the penitentiary for a term of years. The defendant in the case, a physician, well known and respected in this community, both for his integrity as a man and his skill as a physician, was surprised at his home one evening by receiving a call from one of the jurymen. Improper and dishonest proposals were made, the substance of which might be easily guessed. The matter was promptly reported to the judge, and the jurymen was summarily discharged. Had this man not been a fool as well as a knave he would not have played such a bungling hand in his game of intimidation.

We remember a case that attracted considerable attention in Boston some few years ago. The defendant was a surgeon on the staff of the Boston City Hospital, and was also a member of the faculty of the Harvard Medical School, and a man whose high attainments as a surgeon were universally recognized.

The plaintiff, a woman of sixty, had sustained a comminuted fracture of the fibula, which, after three months' treatment, had failed to unite. Her testimony, and that of the witnesses for the prosecution, was to the effect that she was confined practically to a wheel chair, being able to walk but a dozen feet or so, by the aid of crutches, and then only with much pain in the injured member. It was pitiful to see this old lady, on crutches, assisted laboriously to the stand by two attendants—and we have no doubt that the gentlemen of the jury were duly affected and moved to tears, as it was intended they should be.

All went well—the witness had an undeniably good memory, for she had committed her part with care—until she began to get tangled up on the cross-examination. Then she became so excited that she entirely forgot herself, her part, the judge and the jury, and leaving her crutches behind, descended unaided from the stand to shake her fist in the face of the defending attorney, and to call that worthy a damned liar. We believe from later developments that the jury decided she was perfectly justified in her action

and that her sudden improvement was due to the providential intervention of the *faith cure*.

The best surgical talent of Boston appeared on the case, the testimony plainly showing that the defendant had done everything possible for the proper care and treatment of the case. The principal witness for the prosecution was a young man newly graduated from some obscure medical school, with no hospital or other experience to recommend him. His testimony consisted in stating with an offensive smirk upon his face that in his opinion (which of course was valuable) the fracture had not been properly treated. He did not suggest any better treatment, and we could not understand why the attorney for the plaintiff did not press him more urgently in this direction. Finally, he described with great care, elaboration and accuracy the articulation of the fibula with the *ulnar* and sat down with a self-satisfied and superior smile upon his face, and we trusted a blot upon his conscience if, perchance, he were endowed with one. It may have been the aforesaid smile that impressed the jury, for after being closeted for three hours they could not agree upon a verdict, and the case was adjourned until the next session of court.

We do not say that in these days of medical prostitution, where the *osteo-path*, the *electro-path*, the *Christian Scientist* and the various degrees of quacks and humbugs have equal protection under the law with the regular reputable practitioner, that grave mistakes are not frequently made by those licensed to practice the healing art. The moral is therefore significant, when we realize that the pretenders are seldom, if ever, made to face the legal consequences of their blunders. Several deaths from contagious diseases have recently occurred in Boston. The victims were under the care of a *Christian Scientist*, and the consensus of opinion among conservative medical men was to the effect that the patients could have been saved if proper treatment had been used. Yet who ever heard of a *Christian Scientist* being sued for malpractice?

The medical profession is putting forth constant endeavors to so regulate the practice of medicine that the unworthy may be excluded, but it is opposed at every turn by the very class of people—the chronic fault-finders—those whose very delight is to tear down, rather than to build up—who themselves are the most exacting and overbearing when sick.

Medicine is far from an exact science, and it is not likely that it will ever become one—its limitations are too many, and its scope

is too vast. It seemingly abounds with inconsistencies and exceptions. It follows no iron-clad formula, and responds to no universal rule. Disease or injury rarely present complete pictures. An outline is all one can expect, and even that is often poorly defined. The picture is filled in and completed by the individual, and is variously colored according to one's disposition, hereditary qualities, and the many peculiarities that contribute to the individual character, and make every man a distinct equation unto himself and different from all others.

Until these facts are more generally recognized, and less tendency exists to hold the physician responsible for the limitations of the art he practices, suits for malpractice will be many.

Let us bear in mind that the science of medicine, and not the surgeon, is often the real defendant. G. S. S.

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#### OBITUARY.

Dr. M. G. Kolb, who died at his residence, 128 Vega avenue, March 6th, was born in Prague, Austria, in 1858. He came to America when quite young and at the age of 16 secured a position in a drug store. He continued his occupation as a pharmacist until 1882, when he matriculated in the Western Reserve Medical College, from which he received a degree in 1884. He then received appointment as resident physician at the City Hospital, where he served one year.

He located on Pearl street, where he practiced medicine until about six months ago, when he was compelled to retire on account of illness, which was a malignant growth of the rectum.

He always enjoyed a large practice and was most devoted to the profession. He was a great lover of books, and when not engaged in practice could be found in his library reading. He was a most patient sufferer and most considerate of his friends, a man of few words but full of charitable deeds.

He was a member of the Cleveland Medical Society, the Cuyahoga Co. Medical Society, the Ohio State Medical Society and a member of the Visiting Staff of the Lutheran Hospital.

The Medical and Surgical Staff of the Lutheran Hospital at a special meeting held March 6, 1900, passed the following resolutions:

WHEREAS, Our friend and associate, Dr. M. G. Kolb, in the zenith of his usefulness has been removed by death; therefore be it



RESOLVED, That the hospital has sustained a great loss in the death of Dr. Kolb, who has been one of its energetic members since its organization;

RESOLVED, That the profession of medicine has lost one of its most worthy and active representatives;

RESOLVED, That the members of the Staff unite in expressing to the bereaved family their sincere sympathy;

RESOLVED, That these resolutions be entered in the minutes of the Hospital and a copy be sent to the family of the deceased and a copy to each of the medical journals of this city.

W. E. L.

## Periscope.

*Urinary Toxicity.* Labdic-Lagraoe, Boix & Noe conclude from the study of one hundred and twenty collections of the urine for twenty-four hours from eighty persons with albuminuria from kidney diseases or other causes, that no relation exists between the presence or the quantity of albumen in the urine and its urotoxic coefficient, and that the gravity of the prognosis at the present or in the future in a case of Bright's disease depends not upon the presence, absence or quantity of albumen but upon its urotoxic coefficient.—*Compt. Rend., February, 1900.* D. N. K.

## New Books.

CHIRURGIE DU FOIE ET DES VOIES BILIAIRES. By J. Pantaloni, Paris, Institute de Bibliographie Scientifique, 1899.

This interesting volume of 600 pages is devoted, as the author informs us, to a study of all the operations which have been made upon the liver, dealing exclusively with the questions of operative treatment of hepatic affections, and the author seems to have accomplished this extensive purpose of bringing together all the possible or suggested methods for operation that have ever been proposed. After reading this volume, one is impressed with the immense advances in operative methods which have taken place within the last ten years, and have made possible this extensive volume. Starting out with the functions and positions of the liver, he goes on to the question of the best means of reaching the liver, methods of stopping hemorrhage, varieties of suture and ligation, and treatment of cysts and abscesses. One of the

most interesting chapters is that upon the surgery of the gall bladder, in which many most ingenious devices for anastomoses are pictorially represented. Indeed the illustrations throughout the volume are original and illustrate most perfectly the text. Naturally he gives throughout the volume prominence to the work of the French school, and Terrier, Peon and others have apparently been the leading experimenters in the surgery of the liver. The work is an operative surgery rather than a complete text-book, as the indications, the pathology, the results and statistics of operation are not ordinarily given. The volume certainly furnishes the most complete resume of the methods and work of operators in various countries, with all the operations devised, instruments and methods that one could possibly desire.

The simple and direct style in which it is written, and the classification of the topics, make it easy reading, and the illustrations are artistic and fully elucidate the text. The volume will never become a text-book, but the surgeon will here find everything that has been done up to date in the field of hepatic surgery.

PARKER.

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**INTERNATIONAL TEXT BOOK OF SURGERY.** By American and British authors, edited by J. Collins Warren, M. D., LL.D., Professor of Surgery in the Harvard Medical School, and Surgeon of the Massachusetts General Hospital, and A. Pearce Gould, M. S., F. R. C. S., Surgeon to the Middlesex Hospital, Lecturer or Practicing Surgeon and Teacher of Operative Surgery, Middlesex Hospital Medical School, Member of the Court of Examiners of the Royal College of Surgeons of England. Volume I, General and Operative Surgery. With 458 illustrations in the text and 9 full-page plates in colors. Published by W. B. Saunders & Co., Philadelphia.

The authors need offer no apology for making this addition to the list of excellent surgical works already published. As they say, the art and science of modern surgery is still in the transitional stage of its development, and it is advancing so rapidly that another work outlining the present stage of progress in the art and science of surgery must find a useful place in the library of the surgeon. As one reads the work in its various chapters, he is impressed with the fact that this is indeed a modern work in which the old methods find little favor. The early chapters deal most fully and in a most up-to-date manner with the subject of surgical bacteria, localized infections, the surgical pathology of the blood, surgical fevers and the operations followed by infective conditions.

The chapters on operative surgery are excellent, beautifully illustrated, the lines of incision being drawn upon the photographs of actual individuals rather than the ordinary diagrammatic figure. The chapter upon tumors is especially fine. Indeed, the whole volume may be considered as one of the latest and best upon surgery, and is, as its title indicates, an international work, the contributors being drawn about equally from England and the United States.

The second volume upon *Reginal Surgery*, which is soon to appear, will make this a complete and modern textbook of surgery.

PARKER.

**REFRACTION AND HOW TO REFRACT. INCLUDING SECTIONS ON OPTICS, RETINOSCOPY, THE FITTING OF SPECTACLES AND EYE-GLASSES, ETC.**  
By James Thorington, A. M., M. D., Adjunct Professor of Ophthalmology in the Philadelphia Polyclinic; Assistant Surgeon at Wills' Eye Hospital, etc., etc. Octavo; 301 pp.; 200 illustrations, 15 colored. Philadelphia, P. Blakiston's Son & Co., 1900.

Although Dr. Thorington's name is usually associated in our minds more particularly with the subject of retinoscopy, yet he may be accepted as a fully authorized exponent of the views of what is known as the "Philadelphia School" on the whole subject of refraction. Being intended for use as a handbook for beginners in ophthalmology, this book is concise and somewhat dogmatic, omitting extended discussion and demonstration. It is systematic, carrying the student from one topic to another in a way well adapted to give him a working knowledge of the subject, and within the limits prescribed is thorough in its inclusion of topics and treatment of each. A mathematical error has crept into the text on page 63, where the double tangent of two and one-half minutes of angle is given as 0.001425 instead of the correct figures, 0.001454, and the error is carried into all the computations based upon that tangent. Thus the height of the 6-meter letter of the test chart should be 8.7 instead of 8.5 millimeters. This correction is made only as a matter of mathematical accuracy, as it makes a scarcely appreciable difference in the size of the letters. Indeed, letters formed on the scale given would be nearer correct than many charts now in use; as, for instance, in a certain large eye hospital, charts purporting to be Snellen's standard were found, when measured recently by the reviewer, to be based on a scale from one-fifth to one-quarter too large. In treating of a re-



lated subject, astigmatic charts, the author applies to their construction the same scale used for letters, making, if I read aright, lines and spaces each one minute, and a band of three lines and two spaces five minutes in width. But the principle is not the same as with test letters. The exact width of lines giving the greatest contrast in opposite meridians, would depend upon the amount of astigmatism and the acuity of vision, but for general use the best width is about three minutes, which corresponds closely with the width in most charts in use. The percentages given by Dr. Thorington for the various forms of ametropia give a total of 87 per cent. of all eyes as ametropic, leaving 13 per cent. as the total number of emmetropic eyes. This statement is not to be accepted without question. While a knowledge of the true percentage of all persons afflicted with ametropia is much to be desired, it is probable that no observations or investigations yet made supply that desideratum. Most emmetropes and many ametropes never come into the oculist's hands, and the school examinations as usually conducted, while of great value, bring to light only cases of defective vision and manifest error, leaving a greater or less number of cases to be discovered only by later developments or not at all. The above points, of little importance as affecting the value of the book for practical use, are all that have been found to call for criticism, and it will be welcomed by many who have long sought such a guide, but found it not.

F. K. SMITH.

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ATLAS OF LEGAL MEDICINE. By Dr. E. Von Hofmann, Professor of Legal Medicine and Director of the Medico-Legal Institute of Vienna; Authorized Translation from the German edition, by Frederick Peterson, M. D.; Clinical Professor of Mental Diseases in the Women's Medical College, New York; Chief of Clinic, Nervous Department, College of Physicians and Surgeons, New York. Assisted by Aloysius G. J. Kelly, M. D., Instructor in Physician Diagnosis, University of Pennsylvania; Adjunct Professor of Pathology, Philadelphia Polyclinic; Visiting Physician to St. Mary's and St. Agnes' Hospitals; Pathologist to the German Hospital, Philadelphia. Published by W. B. Saunders, 925 Walnut St., Philadelphia, Pa. Price \$3.50.

This is indeed the age of illustration, and medicine and its kindred branches are feeling its effects. The series of atlases known as the "Lehmann Medicinische Handatlanten" had gained a very wide reputation in Europe previous to this, the authorized translation published by W. B. Saunders. These atlases deserve all of the very flattering words that have been used by the review-

ers in praise of their accuracy and beauty. The atlas devoted to legal medicine is no exception to the general rules of excellence. Perhaps no experience is so hard to acquire and dear bought as that of the medico-legal expert. The problem which confronts the post-mortem examiner must be worked out, and anything that can give aid to solution of these problems is of extreme value. This work, coming as it does from Dr. Hofmann, and representing the accumulated experiences of this very able gentleman while in practice of forensic medicine in one of the greatest institutes of legal medicine in the world, cannot fail to be anything but a vast storehouse of knowledge. The splendid plates portray in very life-like colors actual and interesting cases studied in this institute. Careful examination gives the impression of most careful scientific research. It is a book which should be in the hands of the criminal lawyer, the judge at the bench, the student of forensic medicine and especially the coroner who is supposed to bring to the judge and jury the exact facts which were found by him and demonstrated on the post-mortem table. It presents within its covers an amount of knowledge, portrayed so accurately and described so minutely that one can acquire by its study a knowledge that many years of actual experience would alone bring. Mr. Saunders, the publisher, is to be congratulated upon this splendid and valuable reproduction of the "*Lehmann Medicinische Handatlanten*."

ALDRICH.

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A QUIZ COMPEND OF THE DISEASES OF THE EYE. By Geo. M. Gould, A. M., M. D., and Walter L. Pyle, A. M., M. D. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, 1899.

Upon general principles the writer has heretofore unsparingly condemned quiz compends; it was most reluctantly that he consented to review this book, because of his supposedly unalterable opinion that they were all the works of the devil and should be cast into the sea without farther consideration. But, after a careful reading of Gould & Pyle's little work, he wishes to make an exception, and state that this is a safe and reliable book to put in the hands of the medical student, and the general practitioner and even the oculist must find much to commend in its contents.

The illustrations are numerous and good. The language is clear and precise; there is a judicious selection of subject matter and commendable absence of hobby riding. The type is small but clear and legible. There is remarkable freedom from typograph-

ical errors. The price is nominal. The only thing to quarrel about is the title. It is not a *quis compend*, but a good text-book on eye diseases.

BAKER.

**A TEXT-BOOK OF DISEASES OF THE NOSE AND THROAT.** By D. Braden Kyle, M. D., Clinical Professor of Laryngology and Rhinology, Jefferson Medical College; Consulting Laryngologist, Rhinologist and Otolologist, St. Agnes' Hospital; Bacteriologist to the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases; Fellow of the American Laryngological Association, etc. With 175 illustrations, 23 of them in colors. W. B. Saunders, 925 Walnut St., Philadelphia, 1899.

This is a thoroughly practical, clear and concise work.

The diseases are classified according to the pathological alterations which they cause, and each section is complete in itself.

The work is beautifully illustrated with lithographs and original illustrations, and has many attractive features that will commend themselves to both the general practitioner and the specialist.

G. S. S.

## Society Proceedings.

CUYAHOGA COUNTY MEDICAL SOCIETY, MAR. 1, 1900.

May L. Bassett, Medical Reporter.

The regular meeting of the Cuyahoga County Medical Society was held in the Cleveland Medical Library on the evening of March 1st, at 8:30, with the President in the chair. The minutes of the last meeting were read and approved. After business discussions the regular program was called. Owing to the absence of most of the intended speakers, presentation of specimens and cases was called.

Dr. Bunts reported a case of ovarian cyst with twisted pedicle, which appears in full in another column.

Dr. Lower reported an operation for perforated typhoid ulcer eighteen hours after perforation. This also appears elsewhere in this issue.

*Dr. Bunts* (presentation of specimen and report of case): This is a specimen from a case of intussusception in a little child. I operated and drew out the intussusceptum and the child recovered from the operation and lived three weeks, when it was taken with symptoms of obstruction differing from the ordinary symptoms of



intussusception, and died in a short time. I brought up this specimen to show the constricting bands that had formed during the three weeks, as they show so plainly. They cross back and forth, as you see, and there were a great many of them. The gut was invaginated for about eight inches. These bands are very inelastic and held the bowel firmly beneath them when it had slipped underneath, as shown in the specimen.

*Dr. Chadwick:* Supposing you had cut it out instead of pulling it out, would the child have died?

*Dr. Bunts:* Yes; the operation was very difficult as it was, and I think the child would have died on the table if we had done that.

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## Notes and Comments.

**Dr. W. C. Weber** has moved from 405 Prospect St. to The Osborn, 275 Prospect St.

**Dr. Freeman**, of Medina, was in the city on March 19th.

**Dr. I. A. Tripp**, of Nottingham, was laid off duty by sickness for a few days.

**Dr. William Clark** was confined to the house during first week of March with la grippe.

**Dr. and Mrs. B. O. Coates** spent two weeks at Sagerstown during early part of March.

**Dr. W. J. Ritchie** has recently begun practice at Warren, Ohio, coming from London, Ont.

**Dr. William H. Leet**, surgeon for the Nickel Plate at Conneaut, was in the city on the 27th March.

**Dr. Clifford Hiddleston**, of Atwater, O., was in the city on March 9th, and attended the meeting of the Cleveland Medical Society.

**Dr. Charles L. Webster** unfortunately met with another street car accident on February 28th. He is now confined to his house with a lame back.

**Dr. H. G. Sherman** left the city on March 13th for a visit to Washington, D. C., Old Point Comfort and other places. His visit extended over two weeks.

**Dr. Robert Morris**, of New York, delivered an address before the Cleveland Medical Society at their quarterly meeting on Friday evening, March 23rd, his subject being "A Definite Account of My Position on Some Appendicitis Questions." The Saturday morning following he held a clinic at Charity Hospital.

**Dr. A. L. F. Albertson** some time ago sold his property on Willson avenue, this city, and purchased a fine residence in Warren. He has now removed to that place and begun practice.

**Dr. George N. Simpson**, Clev. Col. of P. and S., '88, has not removed to Kansas as announced some time ago, but has been continuously at Warren, where he has an office in the Trumbull block.

**Dr. O. A. Palmer** (Homeopath), of Warren, Ohio, has lately purchased the private hospital of Dr. Martha Canfield on Streator avenue, and will take charge on April 1st. He expects to enlarge it considerably and make numerous improvements.

**Dr. R. D. Gibson**, of Youngstown, recently recovered judgment in the sum of \$156 in a suit for payment for professional services, before the Trumbull county Court of Common Pleas. This was the full amount of the bill for an eye operation and further treatment. It goes to show that juries sometime possess a sense of justice when the rights of a member of the medical profession are involved.

**The Louisiana State Medical Society** will meet at New Orleans, April 19, 20 and 21.

**Professor Osler.** It is stated that Dr. Osler, professor of medicine at Johns Hopkins University, is to be asked to allow himself to be nominated to the chair of the practice of Physic in the University of Edinburgh. The *Medical Press* in this connection avers that the Doctor's reputation is as great in the Old World as in the New.—*Medical News*.

**The Quarterly Meeting of the Cleveland Medical Society** of 23rd of March, was attended by a large representation of the medical fraternity both from Cleveland and the surrounding towns, to listen to Dr. Robert Morris, of New York. The doctor's subject was, "A Definite Account of My Position on Some Appendicitis Questions." On Saturday morning Dr. Morris gave a clinic at Charity Hospital, when he performed two operations. The clinic was also well attended, many of the out-of-town physicians remaining for it.

Among those from out of town we noticed the following :

Canton—Drs. Jacob F. Marchand, James Fraunfelder, Elmer G. Myers, Charles E. Schilling, Edward D. Brant, Harry M. Schuffell, Odo E. Portmann, and Alonzo B. Walker.

Akron—Drs. Dell S. Bowman, Edward O. Leberman, Edward A. Montenyohl, William A. Sackett, Louis S. Sweitzer, Corwin F. Hill, and ——— Lewis.

Massillon—Drs. Henry C. Eyman and T. Clark Miller.

Fremont—Dr. Martin Stamm.

Ashtabula—Dr. John A. Dickson.

North Ridgeville—Dr. Chris. W. Stoll.

Elyria—Dr. Orlando T. Maynard.

**American Proctological Society**, Second Annual Meeting, held at Hotel Richmond, corner 18th and H Streets, Washington, D. C., May 2nd and 3rd, 1900. Program :

Order of Business : Executive Meeting. Reports of Committees. Reading of papers, and discussion of same. Demonstrations by Clinics, and presentation of specimens. Report of Committee on Progress of Proctologic Literature during the past year.

President—Dr. Joseph M. Mathews, Louisville. Vice-President—Dr. James P. Tuttle, New York. Sec'y-Treas.—Dr. William M. Beach, Pittsburg.

Executive Council : Dr. Samuel T. Earle, Jr., Baltimore. Dr. A. Bennett Cooke, Nashville. Dr. J. Rawson Pennington, Chicago.

First Day : 9 a. m. Meeting of the Council. 9:30 a. m. Executive Meeting. Reading of Minutes. Treasurer's Report. Report of Council. Reports of Committees on other than scientific subjects offered. Unfinished business. New business

11 a. m. President's Address, Dr. Joseph M. Mathews, Louisville.

1:30 p. m. Reading of papers. Excision of the Rectum through the Vagina, Dr. Samuel T. Earle, Jr., Baltimore. Curettage vs. Excision in Advanced Malignant Diseases of the Rectum, Report of Cases, Dr. Leon Strauss, St. Louis. A Few Novel Cases in Rectal Surgery, Dr. Samuel G. Gant, New York. Fistula in Ano, Dr. Geo. B. Evans, Dayton, O. The Treatment of Pruritus Ani, Dr. Louis H. Adler, Jr., Philadelphia. Mooted Questions, Dr. A. Bennett Cooke, Nashville.

6 p. m. Dinner of the Society.

8:15 p. m. The Technic of Valvotomy, the Radical Operation for Obstipation, with Practical Demonstration of Proctoscopy, Dr. Thomas Charles Martin, Cleveland.



Second Day. 9:30 a. m. Reading of papers. Catarrhal Proctitis, as a Factor in Constipation or Obstipation and its Radical Treatment, Dr. J. Rawson Pennington, Chicago. Paper, Dr. James P. Tuttle, New York. Rectal Abscess, Dr. William M. Beach, Pittsburg. Submucous Ligatures for Hemorrhoids and Rectal Prolapse, Dr. B. Merrill Ricketts, Cincinnati. Treatment of Internal Hemorrhoids by injection of Caustics or Astringents, Dr. George J. Cook, Indianapolis.

1:30 p. m. Executive meeting. Reading of minutes. Election of members and officers. Miscellaneous business. Adjournment.

**The Samuel D. Gross Prize One Thousand Dollars.** No essay which the trustees deemed worthy of the prize having been received on January 1, 1900, they hereby announce that the prize will be awarded on October 1, 1901. The conditions annexed by the testator are that the prize "Shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens." It is expressly stipulated that the competitor who receives the prize, shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page, it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery. The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 219 S. 13th St., Philadelphia," on or before October 1, 1901. Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize. W. W. Keen, M. D., J. Ewing Mears, M. D., J. Chalmers Da Costa, M. D., Trustees. Philadelphia, February 20, 1900.

## Counter-Irritants.

## Trials of a Naturalist's Wife.

Richard spent the evening in examining some of the minute worms found in the muscles of a man (*Trichina spiralis*) . . . . R. assured me that, in comparison to what surgeons had often to meddle with, it was sweet.

January 5 (1836).—Richard went to Bruton Street to cut up an ostrich. He is now engaged in writing on the "paper nautilus," and there is a lovely little specimen in spirits on the table.

June 21.—Engaged all day in drawing a wombat's brain for R. . . . 26th.—Finished the wombat's brain.

November 17.—Last night a kangaroo (dead) came to R. from the Zoo.

December 28.—Wrapped up the tortoise in flannel before I went to bed, and put it in the cellar.

April 11 (1837).—Dr. A. Farre and Mr. Darwin came here this afternoon. After tea muscular fibre and microscope in the drawing-room.

February 1.—The defunct rhinoceros (late of Wombwell's menagerie) arrived while R. was out. I told the men to take it right to the end of the long passage, where it now lies. As yet I feel indifferent, but when the pie is opened—

February 6.—R. is still at the rhinoceros.

November 21 (1849).—R. brought back with him to dinner Dr. Buckland, Prof. Agassiz, and Dr. Mantell, and afterward entertained them to their hearts' content with the microscope. They made some experiments in blood globules. Dr. Buckland's blood irregular, that of Agassiz regular. Dr. Mantell, who stated that he had a very slow circulation, on examination proved to have blood globules of a decidedly larger size than the others.

April 10 (1843).—He dissected a chimpanzee. Willie watched his father dissecting till he himself smelt like a specimen preserved in rum.

June 11 (1846).—The presence of a portion of the defunct elephant on the premises made me keep all the windows open, especially as the weather is very mild. I got R. to smoke cigars all over the house.

February 16.—Found the cook had a queer-looking bit of fish, which R. had brought in and told her to cook for dinner. There was only part of it in the kitchen, and I did not recognize it. The cook's chief objection seemed to be the name (*Anarrhichas lupus*) which her master had called it, and she was doubtful if a fish with such a name could be a fit thing to send up to a table. It turned out to be what they call a "wolf-fish," and R. declared it not at all bad.—*From the Diary of the Wife of Sir Richard Owen.*

Mrs. Jabber (to Mr. Jabber): "Are you aware that you talk in your sleep?"

Young Jabber (who has just been silenced): "What other chance does he get?"—*Scribner's Magazine.*

## Time.

"Mr. Benson, I waz much pained to heah ob de sullin death ob yer wife. Did dey hol a post-mortem 'zamination?" "Dey did, sah, Mr. Willis; but they didn't hol' it till arter she died. Fool doctah might er knowed he couldn't sabe her life den."—*Journal of Medical Science*.

"Longevity! I should say longevity did run in the family," said Mrs. Spriggins. "Why, John, was six foot two, Bill was six foot four, and George, he had more longevity than any man I ever see. He was six foot seven, if he was a foot."—*Harper's Bazar*.

"My dear," said he to his lady love, "I've been busy all day—not manual labor, you know, but brain work, which is the hardest kind." "Yes, indeed; I know it must be for you." And there was a tender look of sympathy in her eyes which aroused him.—*Exchange*.

A young Scotchman at Aldershot fell ill, and was sent to the hospital. A bath was ordered. It was brought into the chamber where the invalid lay. He looked at it hard for some time, and then threw up his hands and bawled: "O doctor, doctor! I canna drink a' that!"

"I hope my explanation is satisfactory," said Mr. Younghusband, as he continued a long narrative as to why he had been detained down town until 1 a. m.

"Well," yawned Mrs. Younghusband, "your excuse is fairly good, but it's not so good as father used to make."—*Chicago News*.

A little boy was taken by his father into a cafe for dinner. As they were eating their dessert, the father handed the waiter a bill which that worthy carried to the cashier's desk, returning presently with a little pile of change on a silver plate. Robby's eyes grew bright. "Oh, papa," he said, "I'd like a plate of that, too!"—*New York Herald*.

*Experienced Traveller* (at railway restaurant): "When did that man at the other table give his order?" *Waiter*: "'Bout ten minutes ago, sir." "What did he order?" "Beefsteak and onions, sir." "How much did he pay you?" "Sixpence, sir." "Well, here's a shilling. Cook another steak for him, and bring me his." "Yes, sir."—*London Telegraph*.

A song with the title, "There's a Sigh in the Heart," was sent by a young man to his sweetheart; but the paper fell into the hands of the girl's father,—a very unsentimental physician,—who exclaimed: "What wretched, unscientific rubbish is this? Whoever heard of such a case?" He wrote on the outside: "Mistaken diagnosis: no sigh in the heart possible. Sighs relate almost entirely to the lungs and diaphragm!"—*American*.



# THE Cleveland Medical Gazette

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MAY, 1900.

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## Original Articles.

### SOME OF THE CAUSES OF PAINS IN THE FEET.\*

BY C. A. HAMANN, M. D.

Pains in the feet are very frequently encountered, and personally I have many times been at a loss to know how to interpret them. The numerous articulations, with their synovial membranes, the complicated ligamentous and fascial structures, the bursae, the arteries, and the nerves all come in for their share in the production of painful affections. The functions of the foot as an organ of support and progression also expose it to numerous injuries and mechanical alterations. In addition to the local conditions we must consider general and constitutional diseases which are important factors in the causation of foot pains.

It is with the idea of grouping together at least some of these causes, of giving the leading facts in regard to the diagnosis and calling attention to some of the less common affections that I have prepared this paper.

It is not my object to discuss affections or injuries associated with marked and conspicuous anatomical changes, such as the common fractures, tumors, tuberculosis, etc., but rather to consider affections not accompanied by very evident changes of form.

For convenience, a rough classification has been attempted, and we may begin with certain inflammatory affections.

Acute, sub-acute and chronic articular rheumatism of the articulations occur of course. The chronic rheumatic arthritis or arthritis deformans attacks particularly the smaller joints—acute exacerbations of the process are associated with pain.

\* Read before the Cleveland Medical Society.

To these rheumatic inflammations and to gout, I shall only refer in passing. It is to gonorrhoeal inflammations that I wish to allude more in detail.

The various forms of so-called gonorrhoeal rheumatism frequently involve parts of the foot, and the pains produced are often very persistent and resist attempts at cure. Tendon sheaths, joints, bursae and fibrous tissue may be affected, and the manifestations of the process vary greatly as regards clinical signs and duration. The subdivision of gonorrhoeal arthritis into the acute and chronic forms\* is not very satisfactory, inasmuch as most cases begin acutely, but have a chronic course.

Gonorrhoeal rheumatism may be classified into mono and polyarticular forms.

Koenig, from observations on a large number of cases in the Charité in Berlin, makes a classification into four groups: 1st, hydrops articuli; 2d, sero-fibrinous inflammation; 3d, empyema of the joint; 4th, phlegmonous inflammation.

When the metatarsal joints are involved it is hard to determine which ones are the seat of the disease owing to the somewhat diffuse swelling of the soft parts. Indeed, it is likely that several joints are affected, for they are close together and communicate, though not to the same extent as in the wrist; in the foot, as well as in the hand, the numerous tendon sheaths are often involved and give rise to certain peculiarities as contrasted with gonorrhoeal arthritis of the knee. The pain in the acute stages is great as a rule—and there is considerable inflammatory infiltration of the soft parts. The course is apt to be protracted and exacerbations occur from time to time. I have not seen suppuration occur. In the wrist I have met with suppuration and extensive destruction of the carpal bones, necessitating resection of the joint.

The pain may be due to gonorrhoeal fasciitis, or an inflammation of the fibrous tissues and bursae about the heel. These heel pains are not uncommon in gonorrhoeal rheumatism. In the following case is illustrated a somewhat typical form of gonorrhoeal rheumatism in which the bursa between the tendo Achilles and the upper part of the tuberosity of the os calcis, together with the fibrous tissues about the os calcis, were the seat of inflammation:

A. H., aged 19, had gonorrhoea in July, '98. Two attacks since then. About one month later he began to have pain in the right heel. This was followed by pain in the left heel. Standing aggravated the discomfort and he was unable for part of the time to continue his work as a machinist. The urethral discharge was

cured, and all sorts of remedial measures were resorted to for the relief of his heel pains. Protracted rest, blistering, antirheumatics, steel sole plates, and the use of the hot air appliance alike failed to relieve him.

When I saw him about a year after the beginning of his trouble, the following condition was found: Both heels, especially the right, were enlarged—posteriorly and upon the sides there was thickening of the fibrous structures, and a trace of oedema. Upon pressure over the insertion of the tendo Achilles there was considerable pain, also pain on pressure over the under surface of the heel. There was no evidence of flat foot. No joints were involved.

As about all remedial measures had been exhausted, I suggested to him the advisability of opening the bursae, curetting and draining. This was done, with only partial relief, however. At the operation there was found some turbid serum in the bursae. Cultures from the fluid failed to show any micro-organisms.

The term Achillodynia was applied by Albert to cases in which there was pain upon pressure over the insertion of the tendo Achilles, without apparent cause.

It is now known that the causes of this pain are to be sought in an inflammation of the bursa retro-calcanea, which may be due to trauma, either a sudden one, or to repeated friction, as by badly fitting shoes, to gonorrhoea, as in the case above mentioned, to syphilis, to gout, to rheumatism (rarely), and to tuberculosis. In some instances no cause can be definitely determined.

Fournier and Jacquet claim that gonorrhoeal periostitis and osteitis of the os calcis is quite frequent, and they have referred to the condition as the "pied blenorragique." It is much more likely, however, that it is primarily an involvement of the bursa and a secondary thickening and infiltration of the fibrous tissue and periosteum.

Ledderhose has described a peculiar form of plantar fasciitis, which at times is painful and occurs as a result of nutritive disturbances in patients who are confined to bed with fractures or other injuries of the lower extremities; fibrous nodules at times form in the fascia, and these are painful.

The "painful subcutaneous tubercle" of the older writers is also met with in the sole of the foot.

Francke describes a number of cases of fasciitis due to influenza; also joint and periosteal inflammations, all of which gave



rise to pains in the feet. In a more recent article he states that many of these cases, however, are really plantar neuritis.

The possibility of arthritic, periosteal and osseous inflammations being due to typhoid infection is also to be borne in mind.

The various forms of neuritis, traumatic, toxic, etc., may occur in the plantar nerves. I have seen, for instance, a punctured wound in the sole of the foot followed by a severe neuritis of the internal plantar and posterior tibial nerves. Post-typhoidal neuritis of the plantar nerves may occur. Hughes has seen a severe form of plantar neuralgia in caisson disease.

In neuritis the pain is generally of a burning character, and the patient complains of various paraesthesiae.

The diagnosis of plantar neuritis will be based largely upon tenderness of the nerve trunks when pressure is made over them. The lightning pains of locomotor ataxia can only be referred to in passing.

Flat-Foot: This is perhaps the most common cause of pains in the feet and a cause that is often overlooked. It is important to examine carefully the plantar arch in all cases of painful feet. The pain in these cases may be present from the beginning—or it may appear after a twist or a sprain of the previously diseased foot. The pain is not necessarily commensurate with the degree of deformity, mild cases being often associated with considerable suffering. At first there is usually a sense of fatigue, followed after a time by aching; these uncomfortable sensations frequently extend to the calf of the leg, and even to the thigh. As we would expect, exercise increases the discomfort, and rest relieves it. If the condition is unrelieved and the patient persists in standing on his feet, the pain becomes more severe. It exists during the night time, and when the patient awakes in the morning he finds that there is stiffness of the feet.

As the result of over-exertion, sprains, and of inflammatory conditions of the articulations, the pain may be temporarily increased. There are in most cases certain points which are tender upon pressure. One of these is over the inferior calcaneo-navicular ligament which supports the head of the astragalus and is subjected to stretching in flat-foot; in front of and below the internal malleolus, anterior to the tibio-tarsal articulation, and at the bases of the metatarsal bones, are other painful points. Rotating or twisting the foot inwards I have found usually increases the pain.

One frequently finds pain in the feet associated with mild degrees of pes planus and varicose veins of the leg, particularly during and after middle life in women who have become corpulent.

In persons who have been confined to bed for some time I have frequently observed pains in the feet to follow when they first get up. Particularly is this the case if the patient has to walk with crutches as the result of an injury of one limb. The sound limb then has to support the entire weight of the body, the arch of the foot has a tendency to sink down and what we might call acute flat-foot develops. This is, however, a temporary condition and usually disappears soon. The affection described by French writers as "policeman's disease" is probably a manifestation of flat-foot.

Plantar hyperaesthesia may be due to badly-fitting, tight and thin-soled shoes.

The pain in flat-foot is due to the stretching of fibrous, ligamentous and muscular structures, to the contact of parts of the bones not normally in apposition to others, and to inflammatory changes in the articulations.

In recent years there has been considerable discussion among German military surgeons regarding a peculiar form of painful swelling of the foot, seen in soldiers. Not to weary you with details, it may be stated that the condition is due to a partial fracture of one of the metatarsal bones—usually the second or third. The fracture is caused by indirect force and occurs in soldiers who are compelled to make forced marches over rough ground, or who suffer from contusions, twists and falls. There is a painful swelling on the dorsal aspect of a metatarsal bone and examination with the Rontgen rays and the formation of a callus show that a fracture has occurred.

When the leg and foot have been confined in improper positions in the treatment of injuries, such as fractures, there often remain painful conditions of the feet and ankles. In these cases the deformity, as for instance, after a Pott's fracture, chronic inflammatory processes, thickening of fibrous tissues, deposits of callus, and the imprisonment of nerve fibres account for symptoms observed. The affection first described by T. G. Morton, and known as metatarsalgia or Morton's disease of the toes, is characterized by pain in the vicinity of the fourth metatarso-phalangeal articulation; pressure over the joint and lateral compression of the metatarsus increase the pain. At times the patient is unable to wear a

shoe. The disease is much more often encountered in women than in men. It is believed by Morton and others that the pain is caused by the compression of branches of the external plantar nerve between the heads of the fourth and fifth metatarsal bones.

Vascular Disturbances: Changes in the arteries, both in the large as well as in the small ones are responsible for various pains in the feet and legs.

Many cases of senile gangrene, due to thrombosis, embolism or arteritis are preceded for a time by uncomfortable sensations, paraesthesiae and burning pains in the toes. Jonathan Hutchinson also calls attention to cases of "arterial anaesthesia" in which, owing to vascular changes, there is at intervals numbness of the feet. In these cases, the sensory disturbances are probably due to defective nutrition of the nerves.

Erb has recently called attention to cases of "intermittent limping" in which endarteritis, involving the smaller arteries is the causative factor. Charcot, in 1858, first described this condition as due to an obliteration of large arteries. Veterinary surgeons had observed it in horses before this time.

The clinical picture, as represented by Erb, is characteristic: While the patient is at rest he is quite comfortable; after walking for 5, 10, 30 minutes, various sensory, motor and vasomotor disturbances appear—such as itching, crawling sensations, a feeling of coldness, tension of the skin, pain, pallor, cramps, stiffness and difficulty in walking. The feet, calves of the legs and thighs are the seat of these abnormalities, which may reach such a high grade that the sufferer is unable to walk or stand. In some cases there sooner or later appear inflammatory changes in the toes and feet—ulcers form and gangrene may ensue. Erb seeks to show that these disturbances are due to endarteritis obliterans, involving the smaller arteries of the leg and foot. He lays particular emphasis on the disappearance of the pulse in the anterior and posterior tibial arteries, as diagnostic of the affection and insists on a careful examination of these vessels. Erb has shown that by early recognition of the condition and appropriate treatment, much can be done to relieve the patient and defer the onset of the severer symptoms.

v. Manteuffel calls attention to similar cases of angio-sclerotic gangrene, occurring in younger persons; the main symptoms are the severe pains in the feet.



In connection with the above cases, Raynaud's disease and erythromelalgia may be referred to, in which, as is well known, there are vasomotor disturbances.

Referred or Reflex Pains: Pain in the heel has been noticed by many observers in association with urethral stricture; also by von Pitha in a case of vesical calculus. Removal of the stone completely relieved the patient. Renal calculus, inflammation of the neck of the bladder and of the prostate, and neuralgia of the bladder, so-called, may also cause this reflected or referred pain in the heel. The celebrated surgeon, von Pitha, himself suffered from this.

Reflex pains in the feet are sometimes observed in cases of uterine and ovarian diseases.

It unfortunately is the case that in some instances it is impossible to find the cause of the pain, much less to relieve it, and patients go from physician to physician in vain attempts to be cured.

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## REPORT OF CASES OF SYPHILIS OF THE VISCERA.

BY CHAS. F. HOOVER, M. D., CLEVELAND, O.

Late manifestations of syphilis of the viscera in the adult are in the vast majority of cases in the skin, bones and central nervous system, and it is in these instances the most brilliant therapeutic results are obtained. Syphilis of the thoracic and abdominal viscera usually come under our observation after the process has progressed to a degree which renders any therapeutic measures useless. The evidences of syphilis of any of the viscera are those of gross structural changes in the organs which may occur from other etiological factors, so that the diagnosis frequently can be made only by elimination and a therapeutic test. If, however, the patient be seen early in the course of the disease and put under anti-syphilitic treatment, the results of treatment may be as brilliant as we are accustomed to see when the skin and nervous system and skeleton are involved.

I wish to report six cases in which the diagnosis was confirmed by recovery under anti-syphilitic treatment.

Case I., syphilis of the aorta; Case II., syphilis of the myocardium and branch of pulmonary artery; Case III., syphilis of the lung; Case IV., syphilis of the liver, with perihepatitis; Case V., syphilis of the liver and spleen; Case VI., syphilis of the spleen and stomach.

Case I. The first patient was a woman, 65 years of age, who suffered from severe pain in the precordial and left scapular regions, the pain also radiating into the left side of the neck and into the left shoulder; dyspnoea and pain on exertion and fainting attacks in which there was complete loss of consciousness without convulsions, which lasted about five minutes, and recurred about once a week for several months. There were evidences of old gummata of the frontal bone and nasal bones and manubrium; signs of aortitis, viz: pulsus celer, strong pulsation in the second intercostal space at the right of the sternum; systolic thrill over this area, and a palpable diastolic impact. The area of aortic dullness over an inch to the right of the sternum at the second interspace. There was no cardiac enlargement though a systolic murmur was audible over the entire precordial area, with its maximum intensity to the right of the sternum in the second interspace. The aortic diastolic sound was loud and tympanitic in character.

The patient was given iodide of potassium as much as fifty grains three times a day, for a period of two months. Nitroglycerine and nitrite of amyl were also used when the pain was severe or while fainting attacks were threatened. The patient has been under my observation for two and a half years, and for the past two years she has used not nitroglycerine nor nitrite of amyl, nor iodide of potassium, and there have been no fainting attacks, no severe pain, and all physical signs which were originally due to a loss of elasticity, elongation and dilatation of the aortic arch, have entirely disappeared.

I regarded this as a beginning syphilis of the aorta, first, because of the abundant evidences of an old infection and the complete disappearance (under anti-leptic treatment) of all physical evidences of structural change in the aorta. The symptoms and physical signs of chronic aortitis from atheroma could be ameliorated under the treatment which this patient received, but there could not be a complete restoration of the integrity of the aorta as occurred in this case.

Case II. A woman, 40 years of age, in whom there were abundant evidence of an old syphilis, entered the City Hospital in 1895, complaining of attacks of severe pain in the precordial region, which were occasionally followed by haemoptysis and loss of consciousness. These attacks would occur two or three times a week. There was no cough nor expectoration, nor did physical examination reveal any evidences of pulmonary disease. There was never any elevation of temperature. The patient would be

seized with intense pain in the precordial region which lasted a few minutes. After the pain had lasted probably four or five minutes she would become unconscious. The fainting period frequently lasted only a few minutes, at other times a quarter of an hour. The patient was very much prostrated and in a dazed condition. Haemoptysis would sometimes occur before the loss of consciousness, and at other times would not appear until the patient was fully unconscious. During the attacks the pulse was of very small volume and low tension, with a rate of 120 to 140. During the attack one could readily demonstrate an increase in the precordial area of dullness both to the right and left. Ordinarily the heart's dullness extended not quite to the nipple line externally, but during the attack the impulse and cardiac dullness were clearly demonstrable two finger's breadth external to the nipple line. The right boundary of precordial dullness, ordinarily a little to the right of the left sternal border, during the attack reached to the right border of the sternum. Within a few hours the pulse would regain its usual rate, and the heart its former size. There were never any signs of oedema of the lungs during an attack. There were never any clearly demonstrable signs of a lesion either of the aorta or the pulmonary artery.

I here made a diagnosis of syphilis of the pulmonary artery because of the haemoptysis and the evidences of disease of the myocardium which subsided under antisypilitic treatment. The pathological reports show that syphilis of the myocardium is frequently accompanied by syphilis of the branches of the pulmonary artery.

This patient was given mercurial inunctions and iodide of potassium. At the conclusion of about two months' treatment she left the hospital and engaged in general housework, without any recurrence of the attacks for a period of two years. Then the attacks returned as before, and she re-entered the hospital, underwent another course of antisypilitic treatment. The attacks ceased and she was again able to resume her work, and was free from attacks for another year. The precordial pain and haemoptysis and fainting returned and she was brought to the hospital a third time. She refused to take the iodide of potassium after several weeks' treatment and left the hospital only partially recovered.

Case III. A man thirty years old, who for three months had been suffering from pains in both sides of the chest and persistent cough, expectoration of a considerable quantity of mucopurulent sputum, frequently tinged with blood and occasionally small quan-



tities of blood alone. The patient lost his appetite, had night sweats, and had lost greatly in weight and strength. The temperature ranged from 98 degrees F. in the morning to 100-102 degrees F. in the evening. There were frequent chilly sensations experienced, but never any distinct rigor. Physical examination revealed increased resistance and tympanitic percussion note over the lower lobes of both lungs. Respiratory excursion at the lower borders was present though distinctly impaired. Distinct frictions with respiration were palpable at the bases of both lungs in the axillary line. Auscultation showed an abundance of sibilant, coarse and fine, and median mucous rales during inspiration and expiration. There was no bronchial breathing at any point. The pitch of the respiratory sounds was not heightened. The apices over the lobes of both lungs were entirely free from any evidences of disease. This fact suggested the possibility of the process being pulmonary syphilis. The patient's sputum was collected for several days and careful search for tubercle bacilli proved negative. There were but few micro-organisms of any kind to be found in the sputum. Although the patient gave a very indistinct history of a syphilitic infection five years previous he was put on moderate doses of iodide of potassium, which was followed by prompt subsidence of all the symptoms. The cough and expectoration ceased. There were no longer any elevations of temperature; the patient's appetite improved and he increased in weight. He was able to continue his duties as an office clerk.

Case IV. A man 32 years of age, well developed, well nourished. Gave a history of having pain in the lower right thoracic region which has been more or less persistent for the past year. Whenever the pain was particularly severe he had a hacking cough without expectoration. He had local treatment of larynx without any result. There was no elevation of temperature. The gastro-intestinal tract was in good condition. Physical examination showed no signs of disease of the heart or lungs, but the liver was enlarged, reaching three fingers' breadth below the costal border in the nipple line. The left lobe was within two fingers' breadth of the umbilicus. The edge of the liver was sharp; its consistency was increased; there were no evidences of roughening of the surface. Over the hepatic area of dullness in the right hypochondriac region there were distinct friction sounds accompanying respiration due to perihepatitis. The spleen was palpable; of firm consistency; reaching to the costal border on expiration. This patient gave a distinct history of a syphilitic in-

fection eight years ago, and was given mercurial inunctions, and iodide of potassium internally. Within a few weeks the pain and cough and the evidences of perihepatitis had all disappeared. The inunctions and the iodide of potassium were continued for eight weeks. The patient increased in weight and was feeling perfectly well. There was a slight diminution in the volume of the liver but no perceptible alteration in the size of the spleen. This patient's cough was a reflex cough from irritation of the phrenic nerve terminations. In this instance the syphilitic process was that of a chronic interstitial hepatitis. The liver had suffered anatomical changes which remained permanent though the active syphilitic process was arrested.

Case V. A man 35 years of age, whose only complaint was attacks of extreme nervousness, which usually came on in the middle of the morning and persisted for from one to two hours. During these attacks he was wholly unable to attend to any business affairs, but was compelled to lie down. By noon time he again felt fairly well, would be able to eat his midday meal, and spent the remainder of the day in his place of business, and would pass a fairly comfortable night. There was persistent constipation, and the patient had been compelled to use large doses of various cathartics for the past two years. The patient's appetite was good, he ate heartily of all kinds of food. Physical examination revealed no evidence of any disease of the thoracic organs. The liver was enlarged, reaching three fingers' breadth below the costal border, much increased in consistency, thin sharp edge which was slightly sensitive to pressure. Both lobes of the liver were uniformly enlarged. There were no evidences of perihepatitis. The spleen was palpable at the costal border during inspiration. On the lower anterior aspect of the right leg there were three ulcers from old gummata which had remained indolent for the past two years. These ulcers had healed partially from time to time under anti-syphilitic treatment which, however, was not continued more than a few weeks at a time. The patient was given mercurial inunctions, and iodide of potassium internally. At each inunction he used 50 grains of mercurial ointment, and he took 50 grains of iodide of potassium three times a day. The liver and spleen both diminished in size within the first few weeks. The liver receded to the costal border and the spleen was no longer palpable. The old gummata in the leg were completely healed, and after two months' treatment the patient had increased about twenty pounds in weight. He felt much improved in strength,

but the attacks of nervous depression recurred daily, with not the same severity, however; and the constipation though less obstinate still persisted. Abdominal massage was then employed and after two months of daily treatment the patient had a daily passage from the bowels without the use of any cathartics, and the attacks of nervous depression ceased.

These two cases of syphilis of the liver offer a pleasing contrast to those which usually come under the clinician's observation. As a rule the cases of syphilitic hepatitis we see first after the more marked anatomical changes in the liver have occurred, and when the syphilitic pylephlebitis has led to ascites. In my experience such patients do not respond to anti-syphilitic treatment, and the ascites and the gastric hemorrhage or rather hemorrhage from oesophageal piles closes the scene.

Case VI. A man, 40 years of age. Emaciated and blanched; mucous membranes almost colorless. For the past six months the patient has experienced severe pain in the epigastrium following the ingestion of all kinds of food; several attacks of vomiting daily. Physical examination revealed no evidences of disease of the thoracic organs. The liver is not enlarged, but the spleen is very much enlarged, reaching nearly to the umbilicus, the enlargement was uniform. The spleen was of firm consistency, slightly sensitive to pressure, no evidences of perisplenitis. The stomach was not dilated, though at the pyloric end of the stomach in the median line there was an area about the size of a dollar which was very sensitive to deep pressure. On the dorsal aspect of the left arm there was an old syphilitic lesion. The patient's blood showed about 3,000,000 red blood corpuscles; no increase in the number of leucocytes and no nucleated red blood corpuscles. There were no hemorrhages of the retina, nor in the skin, nor from any mucous surfaces. The urine contained neither sugar nor albumen. This patient gave a history of a syphilitic infection six years ago, and besides the lesion on the dorsal aspect of the arm there were no external traces of the old syphilis. But for the cutaneous evidences of syphilis the most probable diagnosis would have been that of splenic anaemia, but in the light of the cutaneous syphilis and the clear history of primary infection, the diagnosis of syphilis of the spleen and stomach was made. The patient was given daily inunctions of 50 grains of mercurial ointment, and 50 grains of iodide of potassium three times a day. Within a very few days after the inauguration of this treatment, the epigastric pain following the ingestion of food became much less, and after about



four weeks he was able to eat all kinds of food without the slightest discomfort. Even during the administration of mercury and the iodide of potassium the patient acquired a good color of the mucous membranes. The spleen receded to the costal border and was no longer sensitive. The epigastric tenderness on pressure entirely disappeared, and after six weeks' treatment he was discharged from the hospital, having gained 25 pounds in weight and feeling able to resume his work—that of a hostler.

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## A PLEA FOR EXAMINATION OF THE MALE GENITALIA IN OBSCURE CASES.\*

BY FERD. C. VALENTINE, M. D.,

Professor of Genito-Urinary Diseases, New York School of Clinical Medicine, etc.

Whenever a female patient with manifestations of a nervous disease comes to the general practitioner or the neurologist, he at once proceeds to establish or eliminate the presence of a genital affection, the possible cause of the ailment for which advice is desired. The propriety of this course is well grounded in practice. Indeed, genital disturbances are such well known factors of reflex neuroses that may simulate many other diseases with no apparent relation to the reproductive apparatus that few if any very recent graduates exist whose first instrument is other than a vaginal speculum. The benefit to our suffering sisters from the clearing up of obscure manifestations of genital disturbance, by exploration of the genitalia, can best be discussed by gynecologists.

But with the masculine patient the affair still remains quite a different one. Indeed, in the vast majority of instances, the man is treated for the manifestations as they arise. When they prove rebellious a neurologist is consulted, and, unless he proceeds as he would in the case of a female patient, he diagnoses the neurosis and advises correct treatment therefor. Still the patient does not get well while the cause of the neurosis continues. Only then it may be resolved to explore the genitalia, to decide whether, in this one case, the neuropathy may not have its origin in the domain of the genito-urinary specialist. If it is found there, the general practitioner and the neurologist quite correctly regret not having taken this simple step before.

\* Stenographic Report of a Clinical Lecture delivered in the Genito-Urinary Department, New York School of Clinical Medicine, February 24, 1900. Reported for the Cleveland Medical Gazette.

This may appear a captious arraignment of the general practitioner and the neurologist. Nothing is further from my mind, especially as I know a number among both who fully endorse the position taken herein, by considering no examination of such a case complete without exploration, tactile and visual, of the genito-urinary apparatus.

Nor do I wish my statements to be taken *pro domo*, i. e., to convey that in every obscure case the genito-urinary specialist should be consulted. Exploration of the genital and urinary apparatus is now so simple, and interpretation of the conditions found so easy, that only in very complex cases will the localized experience of the genito-urinary specialist be needed.

As before suggested, the symptoms of such cases as are now in mind may not at all point to the genito-urinary apparatus. But this is no reason why it, as a factor, should not be sought. Let me illustrate from cases in your own observation in this clinic. It is within the knowledge of every one that pains suggesting rheumatism about the hip joint and radiating down the inner surface of the thighs do not yield to anti-rheumatic treatment. But when the seminal vesicles are interrogated by rectal palpation, the cause of the trouble is found.

There are other pains and symptoms, too numerous to be recited now, simulating disturbances of the gastric, motor, sensory, and circulatory systems, evoked and maintained by a genito-urinary disease. These will never be cured until their cause is treated. And, unless the cause is found, the patient is deemed a neurotic, a hypochondriac, or a "crank," in accordance with the elegance or precision of expression employed by the practitioner. The unfortunate sufferer is treated interminably, goes from physician to physician, from quack to quack, from nostrum to nostrum, keeping in internal valetudinarianism as long as his body and soul hold together, provided he does not before then land in an insane asylum as an incurable dement.

It is my belief that many cases of suicide from unknown causes could be traced to some genito-urinary disturbance of which even the patient was unconscious. Many cases could be cited to support this assumption; it must suffice now to remember one of profound melancholia, that for five years had resisted all treatment. A urethroscopic examination then revealed several rather deep epithelial denudations. They yielded promptly to treatment, and the patient's mind was so quickly restored that an opinion *post hoc*, *propter hoc* seemed entirely justifiable.

Indeed such cases almost daily bring proof that urethral diseases, though not manifest as such until exploration reveals them, can cause other organs and regions to simulate recognized affections, or by vague manifestations simulate imaginary sufferings.

A word regarding exploration of the urethra. It is not rare at all to see a case in which a full-sized metal sound has been passed, or the urethra explored by means of a metal bougie-a-boule, and, no impediment having been discovered, the patient is declared free from abnormality. Without desiring to disparage the diagnostic ability of the gentlemen searching for a urethral impediment in this manner, I would suggest that they use a soft rubber bougie-a-boule, even two numbers smaller than the rigid instrument employed, and only when this is whipped out of the urethra and it encounters none of the characteristic impingement, to pronounce the urethra clear. In the majority of cases they will find an impingement which rigid instruments could not discover.

But there are conditions, such as a slight epithelial denudation, a glandular infiltration, a polypoid growth, which the bougie-a-boule will not reveal. Then the urethroscope, daily employed, *ex necessitate*, by the specialist, manifests one of its most important uses.

The time is passed, however, when this instrument of precision was not available for the general practitioner. The form of urethroscope which I use is so easy of employment and of so slight a cost, that its absence from the office of the conscientious practitioner is no longer justifiable.

Besides instrumental and visual exploration of the urethra, and tactile interrogation of its adnexa, the urine, when examined, will oftentimes give important clues to not only the character but the site of a urethral disease. Having endeavored to outline this elsewhere, (1) I need not attempt to discuss it here.

\* (1) "The Irrigation-Treatment of Gonorrhea, its complications and sequelæ." Wm. Wood & Co., New York, 1900.

## A CASE OF APPENDICITIS IN WHICH THE APPENDIX WAS NOT FOUND AT THE TIME OF OPERATION OR AT THE POST-MORTEM.\*

BY CHARLES B. PARKER, M. D., CLEVELAND.

I report this case simply to record the fact that after quite diligent search during the operation the appendix was not discovered. The operation was made at 9 o'clock at night upon a patient

\* Written for the Cleveland Medical Gazette.



already exhausted, and further search was given up on those grounds. I felt confident at the time that with a better light and the patient in a better physical condition the appendix would have been found. A careful post-mortem examination in the presence of several excellent physicians failed to reveal the appendix. The extensive abscess and attendant sloughing is the only explanation I can offer for this fact. The following interesting history of the case was kindly furnished by the attending physician, Dr. I. A. Elson, of Smithville, Ohio. I give it somewhat abbreviated from his notes.

S. D. B., American, male, married, 45 years old. First attack July 9th, 1897. He was taken with severe pain in the region of the cecum with pain on deep pressure over McBurney's point. No induration could be felt externally or per rectum; no dullness on percussion; no tympanitis; was unable to extend or flex the right leg; bowels constipated; temperature and pulse but slightly above normal; no chill; no nausea or vomiting.

*Treatment.*—By enjoining complete rest, with small doses of morphia hypodermically the first day for the severe pain, full doses of calomel with salts was followed by free evacuations of the bowels and relief from all the symptoms.

On the seventh day patient was up and about his room, and in ten days resumed his ordinary duties and has remained in the best of health until this second attack—February 26th, 1900.

This attack was ushered in with pain in the region of the umbilicus, due, as he supposed, to intestinal colic. Temperature and pulse normal; no chill; no pain over McBurney's point; considerable nausea, and he vomited once or twice. Treatment similar to that used in the first attack was repeated, but without any relief. The pain became localized over McBurney's point. Flexion and extension of the right leg was painful; tongue coated; breath foul; palpation over the appendix producing nausea. Upon March 1st induration was distinctly marked over the appendix, the size, perhaps, of a goose-egg. On deep pressure the doctor thought he could detect pus. He then insisted upon an operation as soon as possible as the only means to save the patient. This was declined. The temperature having gone up to 101.5, the pulse 92, consultation was asked for, and Dr. McMillan, of Orville, saw the patient. He decided to defer the operation until March 4th, and then if the patient was no better at that time to operate at once.

On March 5th the patient had rested well the previous night and felt better. He declined to discuss the question of operation, although the tumor was increasing in size. The patient's general condition became gradually worse. Evidence of fever and its local manifestation, such as disturbance of the stomach, inability to eat, etc., until March 7th, when the general condition of the patient was manifestly most grave. The necessity for the operation to save his life was evident, so a surgeon was called.

Operation was made at 9 p. m., and there were present Drs. Elson, McMillan, Morgan and Warren. Ether was used. Patient rallied from operation slowly. Pulse and temperature fell next morning and the temperature never went above 99 2-5. Patient gradually grew weaker and took very little nourishment. Wound was redressed; looked well; discharged freely. Strychnia, morphia, and stimulants were used freely. Patient gradually sank and died the afternoon of March 10th, two days after operation.

A post-mortem was made, the same gentlemen being present. No general peritonitis. Appendix could not be found after a careful search. The coecum and its mesentery were bound down by very firm adhesions. Abscess cavity extended back of the coecum and had burrowed up into the lumbar muscles toward the liver. Intestines in the whole iliac region were bound together by adhesions. The main abscess started in the region of the appendix. Post-mortem showed that the operation was not performed soon enough.

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## THE ADDRESS OF THE RETIRING PRESIDENT OF THE CUYAHOGA COUNTY MEDICAL SOCIETY.

The year which has just passed has not marked the progress in this society to which we had justly looked forward, and yet it has not been one of idleness on the part of many of its members. I feel in all sincerity that I have failed in many of the implied duties which the acceptance of the presidency of this association has placed upon me. That it has not been through any lack of interest on my part, I am sure you will believe. It has been simply an inability to meet the demands made upon me. In many ways we have advanced, never before in my recollection has the number of papers been so great or their character so excellent as during the past year. Clinical cases and pathological specimens of extreme interest have been presented and the program committee deserve much credit for their persevering efforts which have suc-

ceeded in presenting us with monthly programs of unusual excellence and deserving of much wider and more general interest on the part of the profession in this city. Why our success is not greater, I am sure our incoming president will appreciate and that he will strive to bring things to their natural level we all know, but, and this is a very important but, he must have the help of his fellow members of this society. A passive interest is not sufficient, it must be active, very active, and general in its dissemination throughout the society. I am sure we all love the old society; we have a childish reverence for its useful work in the earlier days of its history. It did its full share toward bringing together the profession of Cleveland, toward shedding a new light upon the work done by the medical men of this city and county. It was an early day pioneer doing its duty steadfastly and straightforward as it saw it. It has done more toward upholding the medical ethics of this community than any one other factor that has ever been in this city, and, gentlemen, I assure you its duties are not ended. We must not in our general confidence that this society will not go wrong, let it drag along, its body bent with years, its head crowned with the wreath of age. We must have a young, vigorous, healthy life infused into it, a life which appreciates the good of the old and the benefits which it must both give and receive. We have added a considerable number of new members to the society during the past year, many of them from among the younger members of the profession, some from those who had left us but have returned. It is needless to say how welcome they all are, but we want more than mere members, we want work and we want it from all, young and old alike. It is only in this way that we can rejuvenate. The program committee has endeavored to make the new members as well as the old feel that their work was needed and wanted. All papers cannot be elaborated to their fullest extent, a certain number necessarily must be, but the short, crisp report of cases of special or general interest are always at hand ready for presentation. How much help may be derived from securing a discussion upon a subject of special interest to the reporter of the case may be appreciated by all and it is perhaps in this class of work, rather than in more elaborate preparations that the younger men may derive advantage. At any rate, let everyone do as he feels best qualified, or in the direction he feels most interested, only *do*, and the success of our society is assured. The continuance of the high grade of work done during the past year is bound to bring its recognition and reward. I shall not at-



tempt to make suggestions to the new president as to how to increase the enthusiasm in and attendance upon our meetings. I am sure it would come with poor grace from me. It is practical work, not theory, that we need, and I am sure that we shall get it.

I had intended in closing my year of service to present to you some subject of general interest and not yet strictly upon any medical subject, and while many thoughts have come to me, none appeals to me with so much force as that of our relations to our patient and to our profession. It is said that this is an age of advance, of breaking down of old barriers and precedents, of putting medicine upon a higher and more scientific basis, and along with these assertions comes the cry that we have too long been dominated by false ethics, that we have wrapped ourselves in a self-made shroud, and have segregated ourselves to our own detriment, that we have allowed the honored and high-born traditions and inspirations of the past to interfere with our successful career as business men. There can be no doubt but that much of this is true, but beware of the reaction! Let the spirit of commercialism once gain a firm foothold in our profession and the inspiring nobility of our calling is gone. I do not mean for one moment that we should not consider our services deserving of full and just compensation. Depreciation of their value can only result in the depreciation of the esteem in which the people hold us, but let us not allow our services ever to be estimated upon a strictly dollar and cents basis. Can the inspiration for noble and untiring work come from an estimate of its value in dollars? Can the responsibility that holds the balance between life and death be measured by any earthly scale? Can the restoration of a mother to her family who mourned her as lost, can the return of the breath of life to the dying infant, be given a value in money? No, I cannot believe that we can ever safely adopt the ordinary principles of business life. It would take from our profession something that, notwithstanding ignorance, prejudice and doubt, has called forth the wondering admiration of thinking men of all ages. The devotion of the best men in the medical profession to their profession is deserving of all admiration and emulation. The commercial spirit is, however, abroad in the land and its results are becoming only too evident. All it lacks is the permission to advertise to place it on the level it seeks. Can you read any of our medical journals and not believe this? Can you not see it cropping out between the lines as plainly as though it were written there? How many articles are written with a desire to impart knowledge to others?

How many articles contain a word or thought that adds to our permanent knowledge? Some, it is true, but what a large number of them are written without appreciation of the responsibility that the expression of such ideas and methods entails? Sweeping conclusions are drawn from the flimsiest premises, deductions of gravest significance are made from single results, new medicines are recommended, new methods urged, new operations devised to attract the attention of those of our profession who do not stop to think, and still more gain the attention of the laity through the press and otherwise to the new things we are doing. To have the appearance of valiantly hewing a path through all the mustered obstacles of tradition and conservatism when we know in our own hearts there is no special merit in it, when we know many other means answer equally well the same end. It is these subterfuges that we must resent. Progress is our aim, but to cumber progress with the tedious bypaths of insincere or misled enthusiasm is to lead us into a maze from which it is difficult to find the outlet. The man with a hobby is as a rule a dangerous man, whether he belongs to our profession or not. Only in other pursuits he can do less harm, since he is recognized and classified as a crank and treated accordingly, but in medicine or surgery this sometimes passes for genius, especially as viewed by the laity and by the thoughtless of our own profession, and he is left free to follow his hobby to the detriment of those who trust their health and happiness and even life to his fancied skill. Dogmas are unsafe, either in religion or in medicine, but in medicine they do most harm, and he whom in his egotistic confidence thinks that he at last thus solved the problem of treatment or operation in a way that is perfect and therefore cannot be altered, is necessarily a man of narrow mind, blinded by self-esteem and over-confidence and therefore a dangerous member of the profession. True, he may have ability, but that ability is over-balanced by the narrow limit of his view and the self-imposed limits of his dogma. I am glad to believe that there is a large and noble body of physicians faithful to the highest and most inspiring traditions of the past, whose eyes the spirit of commercialism can never blind to the sacred duties they owe to their patients, who regard life as a mystery which they must approach with all solemnity and reverence, and I am equally sure that there are others in whom the greed of gain and fame has stamped out the highest attributes of a physician and left in their stead that vaunted spirit of commercialism that sees only self-glory and aggrandizement in the suffering body placed under his care.

## Abstracts and Extracts.

### THE IDEAL DOCTOR.

Dr. Ideal may be well informed in every branch of his profession and ignorant of the religious persuasion of his best paying patron. He is wise enough to know that one may be the largest Methodist and smallest doctor in town; that he may be the most orthodox Baptist and flaunt the hand bills of quackery in your face; he may be the most consistent Campbellite and know nothing of the therapeutic indication of aqua pura; that he may believe in justification by faith and be an ideal medical man; or he may believe there is nothing in the whole affair *but* faith, and it has nothing to do with his competency as a physician; that he may believe in the theory of evolution or he can embrace the dust theory of the origin of man and his qualification as a doctor will remain unaffected; that he may be agnostic in theology and a good physician; or one who deals daily with human life may be agnostic in both.

If a Christian, Dr. Ideal will not go to the amen corner for his patients, and when he offers up an earnest supplication for some brother practitioner's patient, he will not call to inform the sick of the fact; he considers it a private transaction between himself and his Maker, and to let the patient know it would add no efficacy to the prayer.

This doctor always seeks a congenial atmosphere and there are his fastest friendships. He will not compromise an old friend in hope of gaining a new. He is ever faithful to one and never mistrusted by the other. He meets all obligations promptly, to do which he charges what his services are reasonably worth and collects promptly as possible. He is a member of all medical societies he can join and attend; he participates in their councils; he recognizes it as consultation with the best men of the profession, and he is always anxious to meet them; he knows if one lives to himself he will soon become narrow-minded, he grows impatient with his own deficiencies and dissatisfied with his calling; he loses interest in his patients and they have reason to lose interest in him.

He strictly fulfills every engagement and from his counsel others borrow wisdom; he takes pleasure in imparting knowledge. His opinion is sometimes worth having and is given in an unassuming manner to the one with whom he consults; but to the family, very sparingly, except through the attending physician, or



at his request. He was never known to tarry with a patient when the attendant was gone, thus endeavoring to ingratiate himself, by unfair means (into favor), with the family and friends. Any mediocre can, at times, gain advantage of his superiors in the consultation room; only a consummate scoundrel will. Dr. Ideal is not intolerant of the imperfections of others, for to him his own are the greater burden. He has a standard of right and lives to it. He is ambitious; but his ambition is to render others more happy than he found them.—*N. A. Olive, M. D., in Texas Medical Journal.*

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### REMARKS ON THE PRESENT MILD TYPE OF SMALLPOX.

The onset of the present mild type of smallpox does not differ greatly, except in degree, from that commonly seen in the severer form of the disease. The patient is usually taken suddenly ill. A chill, more or less marked, is commonly an early symptom. It may be so mild as to constitute only a slight rigor, so slight indeed, as to pass quite unnoticed by the patient. This is followed by the usual evidences of pyrexia. The temperature may vary from 101 degrees F. to 105 degrees F. High temperature is apt to be accompanied by great restlessness. At the same time irritability of the stomach occurs, which may be only slight, but is often intense and distressing, and may continue throughout the entire stage of the initial fever. Lumbar pain is also very common as an early symptom, and this, too, may be slight or severe. Sometimes it is absent altogether. Encephalic symptoms very frequently accompany this stage. In adults, headache is often severe, and when the temperature is high there may be delirium. In children there is apt to be somnolency, and convulsions often occur. The tendency to syncope, the marked dizziness on assuming the erect position, and the excessive prostration, so common in severe cases of smallpox, are often quite absent in the present mild type of the disease. Indeed, according to information obtained from many of the patients who came under my notice, the entire initial stage was so mild that they were not obliged to remain constantly in bed; some even stated that they had scarcely been ill at all, and yet on close interrogation I was able to learn that all had suffered. In a few the initial stage was marked by its usual severity.

From 48 to 72 hours elapse from the chill or rigor to the first appearance of eruption. The temperature at this time, or very soon after the appearance of the eruption, drops to normal, and all the other symptoms improve correspondingly, leading the patient to believe that all trouble is over. In this he would be sadly mistaken if the disease were the smallpox of former epidemics, but as it prevails at present the initial stage constitutes, in very many cases, the principal part of the illness. The patient now frequently leaves his bed not to return to it again.

The eruption makes its appearance as minute papules, being first seen as a rule on some parts of the face, the forehead and the wrists. Two or three days usually elapse before the outbreak is complete. The papules are sensibly elevated above the surface of the skin, and as they develop they assume the peculiar dense and firm character so commonly described. They change into vesicles somewhat earlier than usual. Not infrequently on the second or third day of the eruptive stage, distinct vesicles are seen. The peculiar condition known as umbilication may be seen in some of the lesions, but not in all. Frequently as early as the fourth or fifth days the vesicles change into pustules, and almost immediately shrinking and drying begin on the face, and a little later on other parts of the body. In some cases the eruption runs a course somewhat longer than that described, but in no instance have I seen it as long and tedious as in what might be styled normal smallpox. In the majority of cases the lesions are discrete and sparsely set. A few, however, exhibit the lesions more copiously, even to the extent of their assuming the semi-confluent or confluent form on the face, and sometimes on parts of the extremities also. Even in these cases the course of the eruption is abnormally short.

In the mildest cases the eruption, instead of passing imperfectly through the various phases of development common to the disease, assumes an abortive form, and recedes at a very early period; or else it develops rapidly into more or less dwarfed forms. A very common phase for the eruption to assume is for the papules to develop into solid conical elevations with small vesicles at their summit containing sero-purulent fluid. When dessication occurs, which is always rapid, and the thin crusts have fallen off, the solid part of the pock remains for a long time, giving the appearance of warty excrescences on the skin. This unsightly condition is most frequently seen on the face, but it eventually disappears without leaving any permanent disfigurement.

It is evident from the behavior of the eruption that the most striking peculiarity of this mild type of variola is the comparatively slight changes that occur in the skin. The lesions, instead of actively involving the deeper layers of the cutaneous integument, appear to develop between the outer epidermis and the layer of cells immediately covering the papilla, and in the latter suppurative changes the true skin becomes only mildly involved. Hence, dermatitis and the consequent intumescence, so common on the face and head in variola vara, are either absent or very mild, and the necrotic changes are, of course, greatly limited. The pustules, therefore, desiccate rapidly, forming comparatively thin scabs, which, when they have fallen off, leave pigmented spots, and but little or no pitting. Even in cases exhibiting a considerable degree of confluence on the face the eruption behaves in the same way. When such a case has reached the state of pustulation a wonderful transformation of the features of the patient is often seen in the course of three or four days by the speedy subsidence of swelling and rapid shedding of the scabs.

In consequence, therefore, of the mild character and short course of the pustular stage, secondary or suppurative fever is by no means a prominent symptom. Indeed, it is not seen at all in the vast majority of cases, and in those in which it does occur it is moderate and of short duration, lasting only a day or two. Severe implication of the mucous membrane of the nasal cavities, the mouth, pharynx, and upper air-passage, which during the pustular stage is often an accessory cause of secondary fever and of death, is not met with in the present type of variola. The phenomenal mildness of the symptoms as a whole, and especially during the suppurative stage when life is usually placed in greatest jeopardy, explains why the mortality from the disease in various parts of the United States for the last two or three years has been practically nil.—*Wm. M. Welch, M. D., in Texas Medical World.*

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### THE DIAGNOSIS OF TYPHOID.

There is no one symptom, nor two symptoms, nor three symptoms that are always present in typhoid fever. Any or all of the usual symptoms may be absent. We do not judge by a few positive signs. The diagnosis is a rational one, and must be often made on circumstantial evidence. Yet few diseases are so certain in their diagnosis as typhoid fever. For instance, very often we meet with cases in which, for from five to eight days, there is slight fever, and in which we sometimes can feel the edge of the



spleen. If rose spots do not develop we are apt to call them simple continued fever. In a number of cases, however, after the cessation of the fever, patients have given the Widal reaction showing that it was really typhoid fever. The Widal test will undoubtedly greatly restrict simple continuous fever as we know it now.

Too much insistence has been given to the abdominal symptoms of typhoid fever. It is very possible for the disease to occur absolutely without abdominal symptoms. Out of thirty-five cases that have been under his care during the last month only four patients have had distinct abdominal symptoms.

Beside the enteric type, there are forms of the disease in which the cerebrospinal, the pulmonary and the renal symptoms are of most importance. Many cases of sporadic cerebrospinal meningitis are undoubtedly typhoid fever of the meninges. Very often the typhoid fever is concealed by the occurrence, in the midst of a more or less continuous fever, of a consolidation of one or more lobes of one or both lungs. Undoubtedly certain cases of so-called acute nephritis are really renal typhoid. The disease may run on without other symptoms until the development of rose spots betrays the nature of the disease. There may be no fever at all, or it may begin very abruptly; there may be rose spots, intestinal symptoms may be entirely absent, and so there may be no diazo-reaction.

The Widal test may be positive only very late in the disease, or may not occur until after the fever has ceased. There may be no leucocytosis.

Repeated chills usually mean malaria. The differential diagnosis of malaria is not so difficult as has been thought. No continued fever diagnosed as malaria here in the North in former times was probably anything but typhoid. The country was shocked during the Spanish-American war by the discrepancy of reports and the disagreement of doctors with regard to the existence of typhoid or malaria in the camps. It was not the army surgeons who were to blame, nor the profession of the country, but the teachers at our medical schools who have not insisted enough on the distinction between these two diseases. Malaria is such an accommodating word. It covers such a multitude of diagnostic sins. It was at least as consoling in its way as the unctuous word Mesopotamia to the old woman in the story. Above Mason and Dixon's line an intermittent fever that does not yield to quinine is not malaria. Practically only tertian fever exists at the North,

and this yields readily to quinine in thirty-six or forty-eight hours. At the South we have the estivo-autumnal type, which gives rise to a remittent fever. The curve reaches a fastigium and then does not vary by a degree perhaps for days. The temperature chart is like a map of the Pennsylvania railroad; that of ordinary malaria is more like the multi-serrated line of the Baltimore & Ohio. The estivo-autumnal type may resist quinine for two or three, or even four or five days. The parasite of the disease, too, is harder to find, so that there is more reason for mistake in diagnosis. Out of a thousand cases\*observed at Baltimore at Johns Hopkins, in only one case did malaria and typhoid occur together. In general and obscure febrile cases it is better to suspect typhoid than malaria. Our position in the matter should not be the Anglo-Saxon one of thinking the case innocent of typhoid until proved, but rather the Gallic position of considering the case guilty of typhoid until it is demonstrated to be innocent.—*Dr. Wm. Osler, in the Medical News.*

### LENGTHENING THE TENDO ACHILLIS.

The Orthopedic Section of the New York Academy of Medicine, with Dr. Judson as chairman, recently discussed the subject with the above title.

Dr. P. A. Hibbs presented five patients affected with talipes equino-varus, the result of infantile paralysis, on whom he had performed a new operation, as follows; The tendo Achillis having been exposed by a parallel incision  $1\frac{1}{2}$  inches in length, made to its outer side, it was cut transversely within  $\frac{1}{2}$  inch of its insertion, through two-thirds of its substance and with the turned knife it was then split upward a certain distance. A quarter of an inch above the end of the longitudinal cut another transverse cut was made from the opposite side through two-thirds of the substance

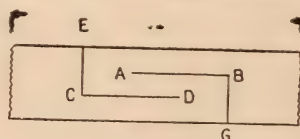


FIG. I.

of the tendon and the knife being turned the tendon was again split to within  $\frac{1}{4}$  inch of the first transverse incision. Thus the tendon was severed in such a manner as to secure its lengthening and at the same time to preserve its continuity. In figure 1 the first transverse cut would be from E to C, the first longitudinal from

C to D, the second transverse from G to B, and the second longitudinal from B to A. When traction was applied lengthening would occur as shown in figure 2, and it would be equal to the sum of the 2 longitudinal cuts minus the sum of the two laps of  $\frac{1}{4}$



FIG. II.

inch each. In figure 1 if C D is  $\frac{1}{2}$  inch, B A  $\frac{1}{2}$  inch, A to E C  $\frac{1}{4}$  inch, and D to G B  $\frac{1}{4}$  inch, then the lengthening would be ( $\frac{1}{2}$  inch plus  $\frac{1}{2}$  inch) minus ( $\frac{1}{4}$  inch plus  $\frac{1}{4}$  inch), or 1 inch minus  $\frac{1}{2}$  inch, or  $\frac{1}{2}$  inch. It was a matter of choice whether the longitudinal of the transverse cuts were made first, but it was important that the skin incision should be to the outer side of the tendon in order to prevent the scar from falling directly over the tendon which might be rubbed by the shoe. Dr. Hibbs had learned since operating by this method that it had been practised in a case of traumatic equinus by Sporon, a Dane (Hospitalltidende, 3d series, Vol. IX, No. 50, 1891).

Case I. In a girl 8 years old, a short tendo Achillis had prevented flexion of the right foot within 10 degrees from a right angle. It was lengthened by this method on Sept. 22, 1899, and the foot was fixed at a right angle. In two weeks slight voluntary motion was allowed and the muscle received daily exercise with some resistance from the attendant. After  $\frac{1}{2}$  inch lengthening had been secured there was positive resistance to any further flexion of the foot than was allowed by the lengthening. The child walked with strong control of the os calcis.

Case II. In a girl 12 years old, flexion of the left foot was impossible within 15 degrees from a right angle. The tendon was lengthened  $\frac{3}{4}$  inch on July 6, 1899. With suitable after treatment the result was an excellent position of the foot with strong action of the muscles of the calf.

Case III. In a girl 14 years old, flexion of the right foot was prevented within 10 degrees from a right angle. The tendon was lengthened  $1\frac{1}{4}$  inch on June 16, 1899, an unusual amount in order to relieve extreme valgus, with resulting good control of the os calcis. As the valgus was recurring a tendon grafting would be done.

Case IV. In a girl 8 years old, the left foot was inflexible within 45 degrees from a right angle, appearing to be almost in a



straight line with the leg. The tendon was lengthened  $1\frac{3}{4}$  inch on June 16, 1899, and the foot fixed at a right angle. It was believed that an ordinary tenotomy would have been followed by loss of usefulness of the calf muscles. It was seen, however, that this action was excellent.

Case V. In a girl 14 years old the right foot had been inflexible within 15 degrees from the right angle and the tendon was lengthened  $\frac{3}{4}$  inch on June 16, 1899, and the foot fixed at 90 degrees. The muscle and tendon showed enough strength to sustain the weight of the body on tip-toe and this had been true of all the cases presented. In no case had an effort been made to correct the equinus beyond a right angle. Further correction might be desirable in congenital, but not in acquired equinus.

That the strength of a tendon lengthened in this way was not seriously impaired was proved by the observation that in every case there had been resistance to the carrying of the flexion beyond the limit allowed by the operation and also by the ability of the muscle and tendon to sustain the body on tip-toe. The process of repair had been rapidly completed after operation by this method, which presented obvious advantages over those in which sutures were applied to the tendon. But the greatest advantage had been found in the readiness and certainty with which the desired amount of lengthening could be exactly secured.

A perfect gait required the "spring" or elastic quality imparted by the muscles which enabled the anterior part of the foot to sustain the weight of the body in walking. Without this power the gait would be that of one who had a wooden foot or a foot affected with talipes calcaneus. In equinus following infantile paralysis it was probable that the muscles were more shortened than the tendon and, as lengthening the muscle was generally impossible, operative relief had to be sought by lengthening the tendon. In operating, however, it was important on the one hand to avoid leaving the tendon so long as to impair the action of the muscle and on the other hand to avoid leaving it so short that the equinus would not be sufficiently overcome. This method enabled the operator to maintain exactly the proper relation between the length of the tendon and that of the muscle. By subcutaneous tenotomy the equinus was readily corrected, but in many cases the result was a serious defect in the gait from undue lengthening of the tendon and resulting shortening and inefficiency of the muscle.

Dr. A. M. Phelps said that it was immaterial whether a muscle was operating at its full length or whether the same

amount of muscle tissue was operating at a shorter leverage. The power was precisely the same, as instanced by putting your arm nearly straight or flexing it. So long as the amount of muscle cells remained the power was the same. Open incisions for primary operations on the tendons should be avoided and in the ordinary subcutaneous operation the tendo Achillis should be made too long if possible by over-correcting, the normal process of repair being relied on to fill in the space between the ends and to secure an accurate and efficient adjustment of the relative lengths of the structures. He had repeatedly seen 4 inches replaced after division of the tendo Achillis and perfect function of the muscle restored.

Dr. Hibbs said that an alteration in the relative length of the muscle and its tendon modified the effect of muscular contraction. If the tendon Achillis was lengthened the contractile power of the muscle cells might remain, but the extent to which the os calcis could be raised by the contraction of the muscle would be lessened. If the muscles of the calf could not momentarily sustain the weight of the body on tip-toe in the act of walking they were not of great use.

Dr. H. L. Taylor said the fear of impairment of function after ordinary tenotomy properly done and followed up was unnecessary. It was formerly the custom after division of the tendon to put the foot up in the deformed position and to correct the deformity at subsequent sittings. Correcting the deformity immediately after the operation was attended with good results. It was possible to elongate the tendon too much, but such cases were rare. He had been looking for years for a case of ununited tendon after tenotomy, but had not found one. The exact amount of correction would vary with the kind of case. It was a matter of judgment. The results in the patients shown were admirable.

Dr. H. Gibney said that he had seen one or two adults in whom the tendons had failed to unite. He could see no advantage in the new operation over the ordinary subcutaneous method after which many cases acquired a length of  $2\frac{1}{2}$  inches. The results shown, however, were excellent and would be better still after tenderness and an indisposition to voluntary motion had worn off.

Dr. J. P. Fiske said that the results shown were good and that the details of the new operation were very interesting. It was, however, a departure from the rule of simplicity which character-

ized the old operation which, almost without exception, gave results which left nothing to be desired.

Dr. A. B. Judson admired the mechanical ingenuity displayed in the operation. A short tendo Achillis produced no deformity and did not interfere with the normal gait excepting in cases in which the tendon was extremely short. Normal flexion of the ankle might be said to be about 40 degrees within a right angle, but with 10 degrees the gait was normal in appearance and ability and the patient experienced no inconvenience, even when assuming the unusual position of squatting. In measuring the equinus it was desirable to have the leg flexed on the thigh in order to relax the gastrocnemii which had their origin in the femur. The foot being held flexed manually, so far as it could be done painlessly, one arm of the goniometer might be made parallel with the crest of the tibia and the other parallel with the inferior surfaces of the os calcis and the head of the 1st metatarsal bone. The degrees could then be read on the scale. In the use of the club-foot brace for congenital equino-varus setting the upright backward from a right angle lengthened the tendo Achillis, which was contrary to what might have been expected. The object of setting it backward was to increase the leverage applied for the reduction of the varus. Lengthening of the tendon followed this adjustment in every case.

Dr. Taylor had a few years ago offered an explanation of this action of the club-foot brace by the theory that, as the inner border of the tendo Achillis was shorter than the outer border, when the foot was rotated outward by the brace the inner border was first put on the stretch and gave way, fibre after fibre, thus unexpectedly lengthening the whole tendon.

Dr. Hibbs said that he had operated in this manner on upwards of twenty patients, but those presented had been the only ones in whom sufficient time had elapsed to make the presentation useful. It was vastly more important to preserve the action of the muscles than to relieve the deformity which was generally not ser-



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## Editorial.

### ERADICATION OF SMALLPOX IN PUERTO RICO AND IN OHIO.

In the November issue of the *Medical News* was an article by Dr. George G. Groff of San Juan, Puerto Rico, entitled "Vaccinating a Nation." In the December issue of the *Journal of the American Medical Association* is an article on a similar subject by Dr. C. O. Probst, Secretary of the Ohio State Board of Health,

entitled "Smallpox in Ohio." These articles make a very interesting comparison. In the first article by Dr. Groff is the statement that in January attention had been called by the reports of the post surgeons in Puerto Rico that there existed in the two months previous some 3,000 cases of smallpox, occurring in sixteen of the seventy-one municipalities into which Puerto Rico is divided. In view of these facts, the Governor-General on January 27, 1899, issued a general order, of which the following is the first paragraph:

"The inhabitants of this island must be protected from smallpox. Every resident who has not had this disease will be vaccinated, and hereafter all infants must be vaccinated before reaching the age of six months."

A general order was next issued appointing or dictating the method of vaccinating the entire number of inhabitants of Puerto Rico. This order appointed five directors of vaccination and five inspectors of vaccination, outlined the territory controlled by each director of vaccination, and allowed the employment of ten physicians under each director of vaccination, for this purpose.

The experience of six months having demonstrated that all virus from the United States had lost its virility on reaching the island, it was decided to establish a "vaccine farm" at Coamo Baths. This was done, and the establishment placed first in the command of Major Azel Ames, U. S. V., later in charge of Captain F. P. Reynolds, U. S. A.

In the beginning of the work, the animals used were tested for tuberculosis. The men engaged in the work were divided into three parties. First, those testing for tuberculosis; second, the vaccinating squad; third, those collecting the virus. The work was done under wall tents, while the cattle were unconfined and lived in the open fields. No trouble was experienced in producing about 15,000 vaccine points each day.

Each director of vaccination was required to report to the chief surgeon weekly, telling of the progress of the work, of the difficulties met with and the number of persons vaccinated and revaccinated. As each person was vaccinated his name, sex, age, color, residence, age of virus used, etc., were all carefully recorded. When he returned for his certificate, the result of the vaccination was noted and recorded. In this way a complete record of the work was preserved.

On June 30th of the same year, a period of six months after the first general order was issued, and three months after the

actual work had begun, reports showed that some 800,000 persons had been vaccinated.

The paper of Dr. Groff closes as follows:

"Many difficulties were encountered. The country and the people were foreign. Their language and customs were strange. Rains swelled the mountain streams to torrents which were often impassible for days at a time. There were no hotels in the country villages, and no means of caring for man or beast, and yet in three working months 800,000 were vaccinated!

"The total cost of the work was \$32,000, or about 4 cents for each person vaccinated, certainly not an extravagant sum for ridding a country of a loathsome disease. At this date, October 20th, not a single case of smallpox is known to either the military or civil authorities, and it may be considered *stamped out* of Puerto Rico. This is the first time this feat has ever been accomplished in a Spanish-American country. Can a similar result not be attained in the other tropical colonies of the Union?"

Comparing the paper of Dr. Groff with the one read by Dr. Probst before the Columbus meeting of the American Medical Association, we note some very radical differences. The paper of Dr. Probst states that smallpox made its appearance in Ohio April 6, 1898, and up to June 6, 1899, a period of fourteen months, there were reported 1,882 cases and 30 deaths. "Out of 88 counties 45 have been invaded, and the disease has prevailed in 61 cities and villages, besides, in most instances, invading rural districts surrounding them.

"In April, 1898, a show known as 'Uncle Tom's Cabin Show,' owned in Columbus, started on its annual tour. Two children, one of them 'Topsy,' and an adult contracted what physicians called to see the patients pronounced 'chicken-pox.' The children were not greatly affected at any time, Topsy taking her part in the play each night. The adult was quite ill for some time. Six distinct outbreaks in as many communities were directly traced to this show. One of these communities where smallpox was thus started is Wapakoneta. The disease began there in May, and it was not until October that an investigation was made or called for, and the disease declared 'smallpox.' The community was largely unvaccinated, most of the children under twelve years of age being unprotected. No restricted measures whatever were employed. Schools and public gatherings continued as usual. The sick were visited and every opportunity was afforded for the spread of the disease. A county fair was held and smallpox pa-



tients in the desquamative stage mingled freely with the visitors. In spite of this great exposure there was comparatively little spread of the disease. In all there were but 203 cases of smallpox in Wapakoneta and vicinity, and the great majority of these occurred before preventive measures of any kind were employed.

"Perhaps a more remarkable behavior of the disease was shown in Marysville, a village of about 4,000 inhabitants. Smallpox appeared there in May, the first three cases having been directly traced to exposure to the troupe referred to above. The disease spread very slowly, attacking children and adults, but only the *unvaccinated*.

"The disease itself has presented many unusual features. It has been not only very mild, but also very feebly contagious. What has been said would indicate this, but other facts show it. One thing, however, stands out prominently, and that is that vaccination, even if performed many years ago, has given almost perfect protection.

"Where the disease has prevailed in a community for months, masked under some other name, vaccination becomes the best means for diagnosis. A house-to-house canvass in such cases, with a history of the patients and their families, revealed the fact that with few exceptions the disease had gone through family after family, picking out only the *unvaccinated*. There was a remarkable instance of this at Marysville. Two families living in adjoining houses in the same yard had the disease. In one family of seven all had smallpox, and all were unvaccinated. In the neighboring family of six but one contracted the disease, and he was the only unvaccinated member of this family. While the disease was so very mild, yet several deaths occurred from hemorrhagic smallpox, and two from the malignant purpuric form."

Comment on these two extracts from these two papers is almost useless. In one case in a nation noted for its lack of sanitary precautions, in a period of nine months from the date of its beginning, with the prevalence of smallpox almost universal, this dreaded disease has been absolutely wiped out simply because there was a central authority with power to insist upon sanitary arrangements, and the power to perform what was necessary under the circumstances.

In the other case the State that is rich and enlightened, blessed with a State Board of Health that is vigorous in its work, and many other local boards of health, notwithstanding all the precautions that have been used, the disease remains still unabated

and still prevalent, particularly here in Cleveland. All authorities agree that vaccination thorough and complete is the only method of stamping out this disease, and yet it remains today in Ohio, with possibly a total expense to the local communities, greater than that incurred in Puerto Rico.

Could anything be a stronger argument for a central authority with power to insist upon and to enforce if necessary all sanitary means and measures for the obliteration of all contagious diseases in the United States? One needs but read these two papers to see the absolute necessity of there being a National Secretary of Health.

W. CLARK.

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### THE PROFESSIONAL NURSE.

Our advice regarding nursing as a profession has not infrequently been asked by young women who are thinking more or less seriously of entering upon it.

Few ever seem to view the field from a thoroughly practical standpoint, and, indeed, it is quite impossible that they should. An imaginary sentiment intoxicates some; others are carried away by a temporary enthusiasm; and only a few seem to realize the hardships, the trials, the worries and petty annoyances, the loss of rest and the irksome confinement, the exposure to disease and the many other drawbacks attached to this most arduous and self-sacrificing work.

Nursing is a serious business, and only those should enter upon it who are well qualified, both physically and by disposition. From the standpoint of dollars and cents it promises smaller returns than many of the other vocations open to women; vocations which require no more preparation, and, in some instances, not so much.

The professional, or "graduate" nurse, receives, as a rule, from fifteen to twenty-five dollars a week, the amount varying somewhat according to circumstances.

If it were possible that one case immediately succeed the other, so that the nurse would receive constant employment throughout the year, at the rate of twenty dollars a week she would get for her labor \$1,040. She would be under the necessity of maintaining her room elsewhere, but her board would be given her. Estimating the table board, for example, at four dollars per week, the value received for the year would be \$1,248.

But such a thing as working fifty-two weeks without inter-

mission would not only be a practical but a physical impossibility. No young woman could stand such a strain.

Including vacations, and enforced idleness, the well-established nurse is occupied, perhaps, nine months of the year at a rate of from fifteen to twenty dollars a week. She would, therefore, be receiving, if all is collected, from \$585 to \$780 in money, and to this should be added the value of board, which would amount to about \$156 for the corresponding time.

In accumulating this sum she must forego, in a large measure, all social pleasures. She is completely wedded to her profession, and must find her pleasures in her work. Her periods of intermission—while on waiting orders, so to speak—are not holidays or intervals of relaxation or enjoyment. As a rule much loss of rest must be made up, accumulated duties at home demand attention, and she must ever hold herself in readiness for the doctor's summons.

Again, the irregularity of living, where the nurse must conform, to a certain extent, to the customs of the various households in which she finds herself a temporary resident, and the uncertain intervals for bodily exercise and mental rest, are not conducive to the best of health.

Then the frequent exposure to disease within the confining atmosphere of the sick room is a fertile source of sickness, for here the nurse is subject to the same sanitary conditions that are often directly responsible for the illness of her patient, and at times when, often, the body is worn out and the mind is weary through loss of rest and constant watchfulness.

Therefore, unless the nurse-to-be has a love for the work itself, and a determination to succeed, and is endowed with a large degree of perseverance and tact, and a goodly amount of endurance, she had best forego entering upon a field where she is sure to score a failure.

G. S. SMITH.

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## THE PHYSICIAN'S DUTY TO THE GONORRHOEIC.

If there is any one organism that has contributed to the work of the gynecologist more than any other, it is the gonococcus. Beginning with Bartholin's glands and the urethra, there is no structure in the genital or urinary tracts of the female it does not invade. The day has gone by when a physician can make light of a case of gonorrhea, and certainly no physician who has kept pace with the advances of his profession will claim now that a case



of gonorrhea is of no more severity than a common cold. The general practitioner knows that there are few patients afflicted with this disease that keep up their treatment until thoroughly cured; that as soon as the pain is relieved and the greatest part of the discharge is gone, the patient deems himself cured and stops treatment. The result is that the gonococcus lies dormant in the urethral glands or seminal vesicles for years, waiting for a favorable time and medium for development. It is not the man particularly who suffers, but the poor woman whom he marries. Tell a man that he has syphilis and he immediately becomes sober and makes it a business to get well; but tell him he has gonorrhea and his greatest concern is to get rid of the annoyance of the discharge; and very likely he is assisted in the opinion that gonorrhea is a trivial affair by the lightness with which the physician treats it. A gonorrhoeic should be told of the dangers that exist to himself by the ravages caused by extension of the disease, and particularly should he be warned of the dangers to his wife-to-be, resulting from an uncured gonorrhoea. He should be urged to continue treatment until all traces of his infection have disappeared, and he should not be discharged as cured until repeated examinations with the microscope have revealed the absence of the gonococcus in the strippings of the seminal ducts and urethral glands, and the mucous membrane of the urethra looks perfectly healthy as examined by the urethroscope. Then and only till then will the physician have done his full duty, and the gynecologist will not meet so often his friend—the gonococcus. W. CLARK.

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#### ASSOCIATION FOR MEDICAL DEFENCE.

Suits for malpractice or blackmail are altogether too prevalent. They are, as a rule, brought by some worthless individual against such of the profession, who chance to be unfortunate in their results, as are thought able to stand the expense. This expense even for defence sometimes becomes enormous and the physician is compelled to stand it simply to protect himself against the malicious onslaught. Realizing the gravity of the situation into which any individual member of the profession may be placed, the Montreal Medico-Chirurgical Society has taken up the matter with a view to the formation of a Dominion Defence Association, and at a recent meeting of that society the following report was submitted:

"That this association realizes that to be the subject of a suit for blackmail is both socially and pecuniarily a matter of the utmost gravity for any member of the profession:

"That it is in the interests of the profession as a body to protect its individual members against such actions:

"That the mere existence of a medical defence association is a strong deterrent against the bringing of such actions:

"That, nevertheless, suits for blackmail are relatively and happily infrequent, and that thus, as experience in the old country shows, when once such an association is started, there is little general enthusiasm with regard to prompt payment of annual fees (which there amount to one pound sterling):

"That there is little likelihood that an association demanding an annual subscription would meet with continued support.

"Your Council would, therefore, conclude that some other scheme has to be sought after and would suggest a scheme somewhat of the following nature, to wit:

"That there be established a Dominion Defence Association, with president and secretary-treasurer; that in each province there be established a branch of this association with provincial vice-president and secretary-treasurer and council of two or three; that the meeting of this main body be annual, to coincide with the meeting of the Canadian Medical Association; that the meetings of the local branches be called as necessity arises.

"That the conditions of membership shall be the payment of an entrance fee of \$5.00, and no subsequent regular annual fee, save if it be found at any time that the amount obtained from these entrance fees is insufficient to cover the cost of defending cases in any given year; that then the membership be assessed throughout the Dominion, the sum not to exceed two dollars (\$2.00) per annum. That failure to respond to this assessment within one month shall, *ipso facto*, remove said practitioner from membership and from benefits of such association, and for renewal of such membership the consent of the central council alone shall be effectual, and payment of entrance fee with assessment in arrears shall be required."

In these suggestions there appears to us to be a first-class working basis for a defence association. That it would be well for all physicians in all lands to have a similar association we fully believe, and no doubt those who have been to the expense and annoyance of defending themselves against a suit for malpractice will heartily concur. To be a member of such an asso-

ciation would no doubt save many a physician, who is striving hard against great disadvantages to obtain good results, but seeing ultimate failure foreshadowed, from worrying over the possibility of a suit prompted by some "friend" of the unfortunate patient.

E. S. LAUDER.

## EDITORIAL NOTES.

Elsewhere in this issue will be found a preliminary program of the meeting of the Ohio State Medical Society, which meets at Columbus on the 9th, 10th and 11th of May, also a preliminary program of the Ohio State Pediatric Society, which meets at Columbus on 8th May.

We welcome to the field of medical journalism the Providence *Medical Journal*, which made its first appearance with the March issue. It has a bright and up-to-date appearance, and we trust it may long continue so. The editor and collaborators are representative men in the profession and will, no doubt, maintain the standing of the *Journal*.

It is gratifying to see editorials of the GAZETTE finding space in contemporary medical publications. When they do appear, however, all we ask is that the GAZETTE receives due credit. In the December issue of the GAZETTE there appeared an editorial, "Koplik's or Flindt's sign," and in the March issue of the Louisville *Journal of Medicine* we see the said editorial finds space and is credited to the Cleveland *Medical Journal*. Of course, this is only a slip of the editor's pen, and we hope said pen may yet give the GAZETTE due credit for what really belongs to it.

E. S. L.

The Seventy-fourth General Assembly, just adjourned at Columbus, not only took steps which we hope will effectually crush illegitimate medical practice in our State, but it also provided generously for the State Hospitals. Thus the Ohio Hospital for Epileptics at Gallipolis received a total appropriation of \$480,400 for the years 1900 and 1901. The construction fund is \$125,000, of which the sum of \$35,000 is available for a general hospital, the need of which has been sorely felt in this community of nearly a



thousand resident patients. An Administration Building costing \$50,000, and two resident cottages for patients for \$40,000 are also authorized by this enactment. New land, including a farming tract is to be purchased. Ample funds are available for the continuation of the work in the pathological laboratory which will probably be transferred to a special building adjoining the contemplated hospital-morgue. An unusual instance of the spirit of the legislature is shown in the special appropriation made for the purpose of enabling this laboratory to send a collection of specimens to the Pathological Exhibit of the American Medical Association. This assembly has certainly shown the kindness of its intentions toward the medical profession of the State, and greater appreciation of the aims of medical science in general than most of its predecessors, for which it deserves our warmest praise.

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### **New Books.**

**INTRODUCTION TO THE OUTLINES OF THE PRINCIPLES OF DIFFERENTIAL DIAGNOSIS WITH CLINICAL MEMORANDA.** By Fred J. Smith, M. A., Oxon, F. R. C. P., London; Physician and Senior Pathologist to the London Hospital. The McMillan Co., 66 Fifth Ave. New York. Price \$2.

This is an attractive little work of some 300 pages, well arranged and well written.

The author does not claim to have written anything that is new, but he has so arranged the subject matter that one can very easily get what is required from it. Those diseases which have symptoms in common and which could easily be mistaken for each other have the different points in diagnosis arranged in parallel columns and so contrasted as to bring out their differences very clearly. He has brought out the underlying principles which govern diseases, and symptoms become very clear once they are understood. The last chapter on emergency cases is particularly valuable.

Altogether it is a very entertaining work which will repay one for the reading.

CLARK.

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**THE IRRIGATION TREATMENT OF GONORRHOEA. ITS LOCAL COMPLICATIONS AND SEQUELAE.** By Fred C. Valentine, M. D., Professor of Genito-Urinary Diseases, New York School of Clinical Medicine; Genito-Urinary Surgeon, West Side German Dispensary; Genito-Urinary Consultant to the United Hebrew Charities to the Metropolitan Hospital and Dispensary, etc., etc.

A work admirably adapted to the demands of the general practitioner, in that it deals with its subject in a manner embrac-

ing each and every essential thoroughly, yet arranged and written in concise terms and applying itself without deviation strictly to the topic in hand. The efficiency of the irrigation method in the treatment of gonorrhoea is now generally recognized by the profession, but in all of the larger works except Guyon it receives only the most casual notice. This fact necessarily adds to the value of Dr. Valentine's work, and since it was through the introduction of the ingenious instrument bearing his name that the method became at all practicable he should receive every consideration for his efforts in bringing about a recognition of the advantages of this form of treatment over the old unsatisfactory and unreliable methods. The want of some drug or systematized technique that would insure a specific result as far as success was concerned has long been felt by the general practitioner, and this is assured him by the author, inasmuch as he justly claims 90 per cent. of cures within fourteen days from the time of the first treatment. Although many articles have appeared during the last two years by Dr. Valentine and other champions of the irrigation method, this is the first work published which sacrifices all other methods of treatment to this one form, and expounding everything from a scientific point of view and dealing as little as possible with empiricism. The book is further devoted to the consideration of the secondary invasions of the urethral adnexa, and the latest instruments for the establishment of a positive diagnosis. The time devoted in going over it is well spent, for it is up to date, well written, and embraces all the newest observations pertaining to the subject of gonorrhoea. STEPP.

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## **Society Proceedings.**

May L. Bassett, Medical Reporter.

### **CUYAHOGA COUNTY MEDICAL SOCIETY.**

The regular meeting of the Cuyahoga County Medical Society was held at the Cleveland Medical Library on Thursday evening, April 5th, with the President, Dr. Bunts, in the chair. After the reading of the minutes of the last meeting and the report of the Treasurer, Dr. Chadwick, a committee, consisting of Drs. Large and F. C. Herrick, was appointed to audit the Treasurer's report. On a motion, which was carried, the President was authorized to appoint a committee to draft suitable resolutions upon the death of one of its members, Dr. M. G. Kolb. Drs.

Lower and Stuart were appointed. The report of the auditing committee stated that the Treasurer's report was correct, and the same was accepted.

The annual election of officers being next in order, it was moved that the chair appoint a nominating committee. The motion was carried, and Drs. Campbell, McNamara and Herrick were appointed. The nominating committee reported as follows:

President—C. J. Aldrich, M. D.

First Vice-President—W. E. Lower, M. D.

Second Vice-President—J. P. Sawyer, M. D.

Secretary—C. C. Stuart, M. D.

Treasurer—L. S. Chadwick, M. D.

Board of Censors—H. A. Becker, M. D.; A. J. McNamara, M. D.; S. H. Large, M. D.

Trustee—Hunter Robb, M. D.

Dr. Campbell moved that the Secretary be instructed to cast the ballot of the society for the election of these officers, which motion was carried. The ex-President then tendered his thanks to the society for their kindness to him during his term of office, and with a few complimentary remarks escorted the President-elect to the chair. Dr. Aldrich expressed his appreciation of the honor conferred upon him by the society, adding that he also realized the amount of care and responsibility that the office brought with it as the experience of the past year had shown, and that he should endeavor faithfully to meet the requirements of his new position. The regular program of the evening was then called, first upon the list being the address of the retiring President, Dr. F. E. Bunts, which will be found in full elsewhere in this issue.

The next paper was by Dr. H. E. Handerson and was entitled "A Resume of the Vital Statistics of Cleveland for 1899." This paper will appear in the June issue of the *GAZETTE*.

Discussion:

*Dr. Sawyer:* I have been much interested in these figures as they have come before us each year, and as I have looked at the black record of the Thirteenth ward I have wondered if an explanation of it might not lie in the fact that it had to bear a large part of the mortality record which belongs to the whole city because it has situated within its boundaries the foundling institution. I do not know whether the deaths occurring there are credited to the ward from which they come or not, but if they are not, this would account for a part of the higher mortality rate which this ward bears.



*Dr. Handerson:* Some time since I wrote to the Health Office asking whether deaths were credited to the hospital or institution in which they occurred or to the ward from which they came, and he replied that they were invariably assigned to the ward from which they came.

*Dr. Sawyer:* I had in mind the Foundling Asylum mainly, for I think that a large proportion of the deaths within it are credited to the ward it is in, because many times it is not known which ward the child came from.

*Dr. Handerson:* If that is the case, of course the greater rate might easily be caused by this fact, but just how much that would influence the statistics I do not know.

*Dr. Sawyer:* Is it not true that the First and Thirteenth wards are rich in alluvial deposits, and that the Sixteenth has better drainage than the others? If this is true, the fact might enforce the importance of avoiding alluvial bottoms.

*Dr. Handerson:* The First and Sixteenth wards both include a large proportion of alluvial deposits.

*Dr. Aldrich:* I remember hearing my father tell that the whole section from Forest street, between Central and Scovill avenues, down as far as Linden street, was a swamp, and that he shot ducks there when a boy.

*Dr. Bunts:* Is it possible to induce the health officers to take careful statistics relative to this matter? And would it not be the proper thing for this society to take action to influence them to do so?

*Dr. Handerson:* I think that it would. At the Paris Exposition this year there will be a revision of the Bertillon system of classification, and I think when this occurs that this city could do no better than to adopt it, as it is the most reliable way of getting at facts from statistics. I do not know how our politics would affect the question, or whether we could force the matter to adoption under our present system.

*Dr. Sawyer:* I think it would be within our province to bring this matter to the attention of the Health Office at least, so I move that a committee consisting of Dr. Handerson, Dr. Bunts, our retiring President, and our present President, be appointed to visit the health officer, requesting that the present method of taking statistics be revised or the Bertillon system adopted.

*Dr. Handerson:* I will say that the Bertillon classification could not well be attended to by the clerks of the Health office. It requires a medical man of experience knowledge and sound

medical discretion. Now the clerk and undertaker decide where all these deaths shall be classified.

*Dr. Webber:* In this connection I would like to inquire if anyone present knows the result of a meeting held here a few years ago jointly among physicians, undertakers and health officers to place the duty to report mortality. I was at that meeting, and as a physician was very much interested but was never able to learn the outcome of the matter. I think we are hardly prepared yet as a society to take this matter up without further study of the manner of taking these statistics.

*Dr. Aldrich:* As I understand it, the recommendation is only a revision of the methods now in use of taking statistics, so that spina bifida will not be classified in our city reports as a disease of the respiratory tract!

*Dr. Sawyer:* I will say that I am acquainted with the present health officer, that he is an intelligent, reasonable man, and that I believe that he would take this matter under careful consideration if he was approached upon the topic by a man like Dr. Handerson, who has made a careful and thorough study of it.

*Dr. Campbell:* I suggest that we would add to this motion a request that the Health Office should be more careful about signing death certificates unless the signature of a physician is attached.

*Dr. Aldrich:* It is a fact that my name was signed to a death certificate this year without my knowledge of the death even.

The question was called for and was carried.

*Dr. Sawyer:* In looking up the point raised a few minutes ago, I find that for the month of November, 1899, the total number of deaths in the Thirteenth ward was 64, of which 16 occurred in the Foundling Asylum. Of course many children come there almost moribund, and the death rate of such an institution is always high anyway. Knowing the painstaking care of the officers and nurses of that institution, I know that this high rate does not depend upon lack of effort in the management. Referring to these statistics you will see that 24 per cent. of the deaths in the Thirteenth ward occurred at this institution.

*Dr. Aldrich:* What is the estimated proportion of colored people in the Thirteenth ward?

*Dr. Handerson:* I do not know.

*Dr. Aldrich:* What about the Twelfth and Fourteenth?

*Dr. Handerson:* The mortality is about the average in the Twelfth and Fourteenth.

*Dr. Aldrich:* The Twelfth has a large proportion of colored people.

*Dr. Handerson:* In closing the discussion, I have little more to say. The location of the greatest mortality is in the Thirteenth ward, and has been something I have studied over a good deal, but if it is true that the foundlings in the asylum, whose wards are unknown, are credited to the Thirteenth, I can see how it would increase the rate. The Sixteenth ward has a zymotic mortality of almost 25 per cent. I have been unable to assign any reason for this unless it is because the death rate among the Jews is high. It is a low-lying ward and slopes down to the river, but its small mortality rate may be merely accidental, like the large mortality rate in the Thirteenth ward. It surprises one to find so high a mortality rate where the number of children is so small. It is usually highest where there are many children.

*Dr. Aldrich:* I have been thinking that the real value of this paper is lost by its being read before so small an audience, and it has occurred to me that the publication of it in some one or more of the lay papers might have a good effect. This might not be considered strictly ethical from one point of view, but if published by the society I do not think it would infringe upon rules of ethics. If it is published only in the medical journals it will be read by none but the physicians, whereas what we wish to accomplish is to interest the public in these questions, for it is something that they need to know. I think it would be read widely by our people if it was published in the Sunday papers.

*Dr. Bunts:* I cannot see any reason for its not being published in the lay papers, for I should think it perfectly ethical.

*Dr. Aldrich:* I would be very glad if the society would take action to this effect, appointing a committee to present the matter to the press.

*Dr. Chadwick:* I move that this paper be given to one or two of the Sunday papers for publication.

This motion was seconded and an amendment offered to the effect that but one of the lay papers be asked to publish it, as it would not probably be accepted by more than one if the other



paper knew that another paper also expected to publish it. After some discussion this amendment was accepted and the motion as amended was passed. The President appointed Drs. Becker and McNamara on the committee to attend to the publication of the paper.

The President appointed the committees of the society for the year as follows:

Executive Committee—J. K. Kofron, M. D., H. W. Quirk, M. D., F. E. Bunts, M. D., C. W. Smith, M. D., J. Perrier, M. D.

Membership Committee—D. P. Allen, M. D., A. R. Baker, M. D., H. W. Rogers, M. D.

Program Committee—F. C. Herrick, M. D., J. P. Sawyer, M. D., Morris Stepp, M. D.

Dr. C. C. Stuart presented a specimen of probable epithelioma of the œsophagus. He said: "I wish to apologize to the society for not having looked up the literature of the subject, but I have not had the time to do so, and will merely present the specimen. The patient from whom it was taken was a male of about 42 years of age, of foreign birth, a carpenter by trade. He began complaining last fall of difficulty in digesting food and also difficulty in swallowing. He was unable to eat solid food, and could only swallow milk by holding it in his mouth for a long time and allowing it to trickle down his throat. The case was not entirely in my care, as Dr. J. R. Smith was also in charge a part of this time. After a time the stricture seemed to entirely disappear. The diagnosis then was that of spasmodic stricture. I had the patient in charge while Dr. Smith was out of the city, and during this time he slept well, ate well, and appeared to be in good health. Later he began to be afraid he was going to have trouble in swallowing, which very soon occurred, and became so troublesome that he could take very little nourishment. Food was regurgitated soon after this, and the case went on to strangulation and death. Upon the post-mortem this growth was found at the junction of the upper and middle third of the œsophagus. The base of the neck at one point showed glandular enlargement.

I did not examine the man myself, but I am almost sure that this was the primary difficulty. There was an opening in the posterior portion of the œsophagus where it communicated with the lung.

After examination of the specimen, the society adjourned.

## Notes and Comments.

**Dr. Roswell Park** is seriously ill at his home in Buffalo.

**Dr. and Mrs. George Seeley** Smith spent Easter in Buffalo.

**Dr. Frank E. Bunts**, was out of the city for a week during April.

**Dr. Theo. B. Breck**, of Hudson, was in the city on the 6th of April.

**Dr. Corbuiser**, of the Marine Hospital, was in Washington last week.

**Dr. Martin Friedrich** has removed from 275 Prospect street to 287 Prospect street.

**Dr. Dudley P. Allen** has returned from a western trip extending over several weeks.

**Dr. Howard S. Straight** has moved into his new home on Edge Hill road, Euclid Heights.

**Dr. Charles M. Hole**, W. R. U., '98, has moved from 393 Cedar avenue to 300 Cedar avenue.

**Dr. John V. Gallagher**, of 800 Superior street, spent a week in New York and Boston during April.

**Dr. Martha H. Jarosch**, C. C. of P. & S., '99, is now installed as House Physician at Hiram House, 183 Orange street.

**Dr. G. A. Feil** was confined to his bed for a week by a severe cold during the latter part of April. He is able to be out again.

**Dr. N. Stone Scott**, after an absence from the city for a few weeks, returned on the 10th of April, much improved in health.

**Dr. William Osler** contradicts the report that he is a candidate for the chair of medicine in the University of Edinburgh.

**Dr. Frank E. Bunts** looked after Dr. Allen's work in the College and at Lakeside Hospital during the absence of the latter.

**Dr. Robert W. Williams**, C. C. of P. & S., '99, has been appointed Surgeon to the Cleveland Terminal and Valley Railroad.

**Dr. Joseph W. Harmon**, a prominent pioneer of Cuyahoga county, and once a well-known resident of Chagrin Falls, died of pneumonia on April 5th at the home of his son, C. S. Harmon, of Chicago.

**Dr. John N. Lenker** has been appointed assistant to the Chair of Laryngology, C. C. of P. & S., and Laryngologist to the Out-Patient Department of the Cleveland General Hospital.

**Dr. and Mrs. Joseph F. Hobson** had occasion to go to Texas the early part of April because of the death of Mrs. Hobson's sister.

**Dr. Charles B. McBurney**, who has for a number of years been chief surgeon to Roosevelt Hospital, in New York, has resigned.

**Dr. Conn. R. Ohliger**, C. C. of P. & S., '98, has been appointed Acting Assistant Surgeon, U. S. A., and has been ordered to San Francisco.

**Dr. and Mrs. A. E. Chatfield**, of Prospect street, have returned from Utica, N. Y., where they were attending the funeral of the Doctor's mother.

**Dr. and Mrs. George W. Crile**, who left Cleveland on the 8th of February for a wedding trip to Japan, have decided to go around the world, and are now in India.

**The Ohio State Pediatric Society**, which meets at Columbus, O., on May 8th at 2 p. m., has issued the following preliminary program. The final program will contain several more papers.

1. "Treatment of Hernia in Children," F. F. Lawrence, M. D., Columbus, O.
2. "Epidemic Catarrhal Fever, G. W. Morehouse, M. D., Sparta, O.
3. "Convulsions in Children," William A. Dickey, M. D., Toledo, O.
4. "A Case of Chorea Following Removal of Adenoids and Tonsils," E. A. Montenyohl, M. D., Akron, O.
5. "Acute Mastoiditis, Following Infectious Diseases, with Report of a Case," John W. Murphy, M. D., Cincinnati, O.
6. "Sources of Milk Contamination and Its Prevention," D. S. Hanson, M. D., Cleveland, O.
7. "Intubation and Antitoxin," H. H. Jacobs, M. D., Akron, O.
8. President's address, T. Clark, Miller, M. D., Massillon, O.
9. "Concerning the Prevention of Lateral Curvature," Albert H. Freiberg, M. D., Cincinnati, O.
10. "Statistical Study of Defective Vision of Cleveland School Children," L. K. Baker, M. D., Cleveland, O.



11. Paper by D. N. Kinsman, M. D., Columbus, O. Title not yet given.

12. "Two attacks of Epidemic Meningitis Occurring Inside of Three Months in a Little Mute, Age Seven Years," Charles J. Aldrich, M. D., Cleveland, O.

13. "Anodynes in Children," R. R. Petitt, M. D., Dayton, O.

14. Dosimetric Medication in Pediatric Practice," M. Borts, M. D., Cleveland, O.

**Preliminary Program Ohio State Medical Society** which meets in the Y. M. C. A. Auditorium, Columbus, May 9, 10 and 11, 1900:

Address in surgery, Nicholas Senn, M. D., Chicago, Ill.

Address in medicine, Walter Wyman, M. D., Washington, D. C., Surgeon-General Marine Hospital Service.

PAPERS.

"The Treatment of Consumptives at Home," Joseph Eichberg, M. D., Cincinnati.

"Inguinal Colostomy," John C. Oliver, M. D., Cincinnati.

"The Oro-Pharyngeal Ring of Lymphadenoid Tissue," Thos. Hubbard, M. D., Toledo.

"The Physician in Municipal Reform," D. R. Silver, M. D., Sidney.

"The Value of a Healthy Throat," W. W. Pennell, M. D., Fredericktown.

"Tonsillar Obstruction in the Fauces and Pharynx," A. W. Francis, M. D., Ripley.

Paper, D. N. Kinsman, M. D., Columbus.

"Subphrenic Abscess Following Appendicitis," J. F. Baldwin, M. D., Columbus.

Discussion opened by A. H. Freiberg, M. D., Cincinnati.

"Pelvic Suppuration," F. F. Lawrence, M. D., Columbus.

"A Plea for the Earlier Use of the Obstetrical Forceps," J. M. Fassig, M. D., Zanesville.

"Round Ligament Ventro-Suspension of the Uterus—A New Method," D. Tod Gilliam, M. D., Columbus.

"Alcohol—Its Place," R. T. Trimble, M. D., New Vienna.

"The Medical Treatment of Gallstones," E. S. Stevens, M. D., Lebanon.

"The Treatment of Ulcers of the Leg," S. S. Halderman, M. D., Portsmouth.

"Sudden Deaths," Lous Schwab, M. D., Cincinnati.

"Three Laparotomies for Gunshot Wounds," E. W. Walker, M. D., Cincinnati.

"The Diagnosis of the Position of the Foetus in Utero by External Examination," E. Gustav Zinke, M. D., Cincinnati.

"Puerperal Eclampsia; Its Causes and Treatment," John E. Sylvester, M. D., Wellston.

"Pleurisy in Childhood," T. W. Rankin, M. D., Columbus.

"The Fraenkel Treatment of Locomotor Ataxia," D. I. Wolfstein, M. D., Cincinnati.

"The Differential Diagnosis and Treatment of Metatarsalgia," A. H. Freiberg, Cincinnati.

"Operations Upon the Biliary Passages," Dudley P. Allen, M. D., Cleveland.

"Nasal Polypi in the Naso-Pharynx," John M. Ingersoll, M. D., Cleveland.

"Cerebro-Spinal Meningitis," Charles J. Aldrich, M. D., Cleveland.

"Report of Some Operations on the Intestine," Charles S. Hamilton, M. D., Columbus.

"The Value of Posture in the Treatment of Rectal Diseases," Thomas Charles Martin, M. D., Cleveland.

"Pyloric Stenosis Without Dilatation," N. Stone Scott, M. D., Cleveland.

"The Surgical Treatment of Ulcer of the Stomach and Duodenum," Ralph J. Wenner, M. D., Cleveland.

"Eye Strain," Louis Stricker, M. D., Cincinnati.

"Perforation Wounds of the Eyeball," C. W. Tangemann, M. D., Cincinnati.

"The Infectiousness of Follicular Tonsillitis," C. A. Hough, M. D., Lebanon.

"Hipjoint Amputation," W. D. Hamilton, M. D., Columbus.

"Atypical Cases of Appendicitis," W. J. Means, M. D., Columbus.

**Some Directions as to the Care of the Hair.** There are certain matters in regard to the care of the hair that have not been taught to some physicians in their student days, and about which they are still somewhat at sea because they have found no mention of them in their books. About these they seek advice. Perhaps such matters may seem trivial to some of you, but they do not seem trivial to some of your patients. Therefore, they seem to me to be of sufficient importance to warrant my bringing them briefly to your notice.

Management of the Hair During and After Fevers.—It is well known that the hair falls after fevers and parturition, as well as after other exhausting drains on the general nutrition of the body. The laity know this, and in such cases are constantly asking if we cannot do something to prevent the fall of the hair. After the patient is convalescent, his or her, especially *her*, friends are eager to have the head shaved and cross-shaved, and cite cases of those who have had this done and now have such magnificent hair! How shall we answer these questions? We can answer the first by saying that nothing can be done during the illness to prevent the fall of the hair. The hair falls not because of the dryness of the scalp in consequence of the fever, but because its nutrition has been interfered with by the illness. This we know because the hair will fall in some non-febrile disease. All we can do is to keep the hair and scalp in order by gentle brushing and combing, and by rubbing into the scalp once or twice a week the least little bit of vaseline or oil. To the demand for permission to cut the hair short or to shave the scalp, we should give emphatic denial. It is a serious business to shave the scalp of a woman and chiefly benefits the barber, who by the way, is the one most urgent to have it done. It dooms the woman to months of wearing a wig, and to many subsequent months of remarks from the thoughtless and cruel because she, perforce, is a member of the short-haired sisterhood. As it is impossible to say how much of the hair will fall, and as it is rare for enough to fall to render "doing up" impracticable, there seems to be no reason to subject the woman to the positive annoyances of the shaving with advantages so exceedingly doubtful.

Well, shall we do nothing but simply fold our hands and let Dame Nature look after the hair? It would be much wiser to do this than to do some things that are done; but we can do more. We should allay the fears of the patient and her friends by assuring them that although the hair may fall for a few weeks, it will grow in as well as before the fever if they will obey directions. They must be directed to brush and comb the hair every day. At this they will throw up their hands in horror and exclaim: "Why, doctor, I am afraid to brush my hair as so much comes out." We can tell them that that need not disturb them in the least, as only the already damaged hair can be pulled out in that way and that the sooner they are out the better. Once or twice a week a little of a pomade composed of a dram of precipitated sulphur in an ounce of a good, soft cold-cream should be gently worked



into the scalp. Every two or three weeks the hair and scalp should be washed, and a little of the pomade applied as soon as the hair is dried. As the patient regains her strength, if she follows this method of caring for the hair, she will be rewarded by having as fine a growth of hair as she had before, if not finer. Of course, the older a woman is the less probability for the much-to-be-desired outcome.

How Often Shall the Scalp Be Washed?—This is another question often asked. We can answer that once in two to four weeks is sufficient, so far as the hair is concerned. In fact, it does not seem to make much difference to the hair whether it is washed or not. It is more cleanly to wash the hair and that is the greatest reason in favor of doing it. It is bad to wash the hair too often, and daily sousing of the hair, as is the too common practice, is pernicious.

Soaps.—We will be asked what soap is best to use in washing the scalp, and many women who make their living by caring for the hair have some mysterious soap which they use, vaunt, and try to sell to their customers, but the composition of which they will not reveal. As a matter of fact, except in a very few conditions of the scalp, it makes little difference what sort of soap is used, provided it is made by a good manufacturer. The most convenient soap is one that is liquid, such as the tincture of green soap. Whatever soap is used must be thoroughly washed out with plenty of water. After washing the scalp a little pomade or oil must be rubbed into the scalp to take the place of the natural oil that has been removed by washing.—*Dr. George Thomas Jackson, in Medical News.*

### **New Books to be found in the Cleveland Medical Library.**

Donated by Secretaries.—Transactions—Indiana Med. Soc. 1899. American Med. Psycholog. Assoc. 1899. Rhode Island Med. Soc. 1897. Tennessee State Med. Soc. 1899. South Hom. Med. Assoc. 1899. New York State Med. Assoc. 1898. Luzerne Co. Med. Soc. 1897. Louisiana State Med. Soc. 1899. Texas State Med. Soc. 1891-7, 1899. Colorado State Med. Soc. 1899. New Hampshire Med. Soc. 1879-1899.

Hon. T. E. Burton.—U. S. Report Bureau of Animal Industry 1887-1898.

Dr. Hamann.—Gould's American Year Book of Medicine and Surgery 1900. 2 vols.

Dr. Henderson.—Allis, Oscar H. *The Hip*. (Gross Prize Essay) 1896.

Dr. Dudley P. Allen.—*International Text Book of Surgery*. Vol 2. 1900.

Dr. J. C. Warren, through Dr. Allen.—*Life of John Warren*. *Life of John Collins Warren*.

Dr. A. J. Cook.—*Chirurgical Treatises*, 1734.

Purchased—Kocher's *Operative Surgery*, 1895.

Foster's *Physiology*, 1895.

*Progressive Medicine*, March 1900.

Hamilton's *System of Legal Medicine*, 2 vols., 1900.

*Transactions Mississippi Valley Med. Assoc.* 1899.

Schaeffer, O., *Obstetric Diagnosis and Treatment*, 1896, 2 vols.

Egbert—*Hygiene and Sanitation*, 1898..

Rohe—*Text Book of Hygiene*, 1897.

Edinger, Hall—*Anatomy of the Central Nervous System in Man and of Vertebrates in General*, 1897.

Jakob, C. B.—*Nervous Diseases*, 1896.

Lehmann and Neumann, *Bacteriology*, 1897.

Bollinger—*Essentials of Pathological Anatomy*, 2 vols., 1898.

Lydston—*Surgical Diseases of the Gen-Urin. Tract. etc.* 1899.

Morris—*Diseases of the Skin*, 1898.

Gant—*Diseases of the Rectum and Anus*, 1898.

Gottheil, W. S.—*Illustrated Skin Diseases*, 1900.

Haig—*Uric Acid in Causation of Diseases*, 1897.

**The New York Genito-Urinary Society** has been organized with the following officer-bearers: President, Dr. Ramon Guiteras, professor of genito-urinary diseases in the New York Post-Graduate School and Hospital; First Vice-President, Dr. Winfield Ayres, Bellevue Hospital; Second Vice-President, Dr. Otis K. Newell, formerly of the Harvard Medical School, now of New York; Treasurer, Dr. George W. Blanchard; Secretary, Dr. A. D. Mabie; Corresponding Secretary and Stenographer, Mr. Samuel Bennett, 161 Garfield Place, Brooklyn, from whom information as to terms of membership, etc., may be obtained. It is intended to confine the membership to medical men actively engaged in clinical work in connection with the specialty, and to hold meetings monthly, at which cases will be reported and papers read. Correspondence is invited with specialists in other parts of the country and abroad.

**To a Young Physician.**

The paths of pain are thine; go forth  
With healing and with hope;  
The suffering of a sin sick earth  
Shall give thee ample scope.

Smite down the dragons fell and strong  
Whose breath is fever fire;  
No knight of table or of song  
Encountered foes more dire.

The holiest task by heaven decreed,  
An errand all Divine,  
The burden of our mortal need  
To render less is thine.

No crusade thine for cross or grave,  
But for the living man;  
Go forth to succor and to save  
All that thy skilled hands can.

Before the unveiled mysteries  
Of life and death go stand,  
With guarded lips and reverent eyes  
And pure of heart and hand.

So shalt thou be with power endowed  
For Him who went about  
The Syrian hill paths, doing good  
And casting devils out.

The Holy Helper liveth yet,  
Thy Friend and Guide to be;  
The Healer by Gennesaret  
Shall walk the rounds with thee.

JOHN GREENLEAF WHITTIER.

**A Physician of North Adams, Mass.,** has been sued by a young woman who agreed to furnish skin for grafting, but contends that she lost more skin than was necessary or authorized. The court held that since no definite area of skin was conveyed in the terms of the contract, the surgeon was entitled to as much of her hide as he chose to remove. In other words, the plaintiff was not more skinned against than skinning.—*Maryland Medical Journal.*



## Counter-Irritants.

### The Tongue in Diagnosis.

*Doctor*: "Are you feeling very ill? Let me see your tongue, please."

*Patient*: "It's no use, doctor; no tongue can tell how bad I feel."—*The Doctor*.

*An Ambiguous Compliment*: "If you use my mixture once," said the patent-medicine man, "I'm sure you will never use any other." "No," was the reply, "I don't suppose I ever would."

"Pa," said Bobby, sleepily, "can I ask you one more question if 'taint foolish?"

"Ya'as, one more."

"How much older is a ripe old age than a green old age?"—*Life*.

### An Honest M. D.

*Worried Wife*: "Oh, doctor; what has detained you? I sent for you at 12 o'clock; my husband is very low, indeed."

*Doctor* (complacently): "Yes, I received your call then, but as I had an engagement with another patient in this neighborhood at 6 o'clock, I thought I'd make one job of it and kill two birds with one stone."—*The Doctor*.

The following is told of Edmund Clarence Stedman, the well-known poet and critic: A report was circulated that Bishop Potter had suggested making one of the chapels in the new Cathedral of St. John the Divine at New York a poets' corner, for the entombment of Americans distinguished in literature. Mr. Stedman thereupon sent word that he would like to select the first five or six poets to kill.—*Exchange*.

A priest who was notorious for his frequent absence from his parish one day called upon the Archbishop Ryan to ask him for a vacation. "His health required it," he said. "Do the physicians say that you need a change of air?" asked the prelate. "They do, your grace." "Then how would it do for you try the air of your parish for a month or two?"—*San Francisco Chronicle*.

### A Political Necessity.

It seems that the existence of Christian science as a legalized practice in Illinois is a political necessity. It is one of those unfortunate situations that reminds us of the story of the deacon and the calf; the microcephalic idiot it is presumed in this instance, is the Christian scientist. The deacon (the legislative committee) evidently had a hard time, and if the hole in the fence (the Christian science clause) was the only feasible way of handling the calf, then the good and loyal physicians of Illinois should not worry, if a few innocent children die, or a few credulous "old fools" shuffle off or "pass over" by the aid of the open door policy. It is a political necessity. We all know that civilization in its evolution must call upon some to be martyrs; others must die that the world may move on, and if death is the only lever capable of moving legislators, it may be a plausible excuse to let the innocent children die that some good may come out of Nazareth. Christian science exists in Illinois as a political necessity, and as such it must live on. For policy's sake it must exist. It is not right, but right or wrong, it is a necessity. *Pro bono publico.*—*The Medical Fortnightly.*

*Notwed:* "S'pose you're going to the picnic tomorrow?"

*Beccwed:* "Not exactly going to one, but I'll be where there is one. I'm going to stay home and mind the baby while my wife goes."—*Columbus (O.) State Journal.*

### When to Retire.

Early to bed and early to rise does very well for preachers and guys, but makes a man miss all the fun when he dies and joins the old stiffs that are up in the skies. Go to bed when you please, and lie at your ease, and you'll die just the same from a Latin disease.—*Monthly Retrospect.*

A charity patient recently died at the Baptist Hospital in Chicago. Five thousand dollars were found sewed into his clothing, much of it in gold. The coins were some of them worn smooth, and a leather purse was half filled with gold dust.—*Maryland Medical Journal.*

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## Original Articles.

### THE PROGRESS AND SOME OF THE PRESENT DEMANDS OF SCHOOL HYGIENE IN THE CLEVELAND PUBLIC SCHOOLS.

BY LEIGH K. BAKER, M. D., CLEVELAND.

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Leading authorities consider the following within the province of school hygiene:

School Diseases.—Of special senses—deafness, astigmatism, myopia. Skeletal—curvature and rotation of the spine. Nervous—chorea, headache, etc. Of respiratory tract—nose, internal ear, throat and lungs. General infectious diseases—eruptive fevers. Contagious diseases of the eyes and skin. Parasitic diseases.

Personal Hygiene.—Isolation of pupils. Disinfection of buildings, furniture and children. Inspection of convalescents. Personal hygiene of pupils regarding food, clothing, sleep, exercise, cleanliness and bathing.

Hygiene of Instruction.—Observation of the effects of the course of study on the health of teachers and pupils (25 items of interest).

Physical Training or Education.—Gymnastics. School plays and athletics.

School Grounds.—Site, area and arrangement.

Buildings.—Ornamentation, foundation, basement, height, finish, entrance, halls, corridors, wardrobes, staircases.

Rooms.—Dimensions, lighting, placing of furniture, colors, blackboards.



Seating and Desking.—Easily adjustable in four directions. Changed by teacher two or more times per year to fit pupil, if necessary.

Ventilation.—Temperature records. Air tests. Location and size of inlets and outlets. Systems of heating. Supervision of ventilation.

Sewerage and Cleaning.—Examination of plans for sewerage with suggestions of alterations where necessary. Inspection of cleaning of buildings with regulations for cleaning and disinfection.

Of the Special Senses.—For some years this subject has received considerable attention. During the current year the ears and eyes of all of the pupils in the grade schools are being tested by the teachers. For the most part this work has been completed.

Through the use of Galle's test many cases of partial deafness have been detected. Whenever a case is found the pupil is seated in such a position in the room as will render it easier for him to understand the words of the teacher. The parents are notified, and in many cases they have had the child treated. In addition a school has been established for deaf pupils, to which they are sent when it is to their advantage.

A large amount of time has been devoted to testing the eyes of all of the grade pupils. But since the CLEVELAND MEDICAL GAZETTE and the *Cleveland Journal of Medicine* have recently published accounts of this work I will merely refer to it. We certainly have found plenty of territory for valuable investigation in connection with the special senses.

Curvature of the Spine.—Each year observations are made in order to ascertain whether or not there is improvement in the carriage of the children.

Five years ago over three hundred eighth grade children were examined individually with reference to curvatures. At this time the general appearance of many schools, while in the standing position, was noted. Very many of the children were evidently crooked. This fact determined largely the character of the physical exercises which have been in use. Almost every exercise prescribed is directly for the purpose of preventing curvatures of the spine. Exercises and games at home as well as at school have been encouraged. In addition vertical script has been introduced and the school program has been interlarded with rest and recreation periods.

If all of the teachers were as successful as are 70 per cent., and if some 30 per cent. of the weaker children were as vigorous as are the other 70 per cent., we should now see but few marked cases of curvature. But with some teachers indifferent in the application of physical education and with many weak pupils we must not be surprised to find many crooked pupils within the schools. This year more than usual attention has been given to the matter, and it can be seen that more of the seventh and eighth grade schools stand well than has been the case heretofore.

Neurasthenia.—Inquiry in some districts has shown that many children complain of frequent headache and of other symptoms of nervous disorders. That teachers who are not well qualified for city school work and well fortified by nature with a vigorous physique are quite liable to succumb, sooner or later, to the constant nervous strain incident to school life. At the same time more attention is being called to diseases of the nervous system, and to the subject of crime in connection with the degeneracy of this system. Very naturally all this raises questions as to the effect of elementary education upon the development of this most important part of the individual.

In so far as these symptoms are due to eye strain in connection with poorly lighted rooms, excessive amount of written work or blackboard work, poor ventilation and excessive examinations considerable improvement has taken place. The course of studies has been modified in favor of the normal development of the nervous system. Undoubtedly the greatest change for the better consists in the change in spirit within the teaching force. As the years go by the tension within the rooms is lessening and more and more of genuine sympathy between principals and teachers and pupils becomes apparent. Striking evidence exists in many rooms that a thoroughly skillful and at the same time wholesome, good-natured teacher is the best preventive of nervous disorders among school children. The standard has been raised at the Normal School and a strong effort is being made to produce such teachers. Unfortunately, many of our teachers, who, with schools of moderate size in sanitary rooms would be able to maintain the cheerful atmosphere so conducive to the proper development of the nervous system, have fifty or more pupils and teach in one of the "143 unhygienic rooms which were never designed for school purposes." In many cases teachers who would be successful under more favorable conditions are gradually worn out and before the first of February they are unfit

for cheerful, inspiring service. During February and March the substitute list is large. In connection with buildings further observations on this topic will be made.

Infectious Diseases.—The management of these is in the hands of the City Health Department. Cases of contagious diseases of the eyes and skin and parasitic diseases are often referred to supervisors by the principals. The parents of such cases are notified with the request that they consult the family physician, or, in case of indigency, they are directed to go to some hospital. It is astounding how bad some of these cases become before they can be induced to apply for treatment. Usually, however, the parents attend to the matter.

#### PERSONAL HYGIENE OF PUPILS.

City Health Office.—This branch of the Police Department has in charge such matters as the isolation of pupils, disinfection of buildings, furniture and children, vaccination, and the inspection of convalescents.

Physiology and Hygiene.—To promote the improvement of children in such matters of personal hygiene as food, clothing, sleep, exercise, cleanliness and bathing, the superintendent arranged an excellent course in physiology and hygiene. It runs through the entire school course. In the upper grades forty minutes a week are devoted to the subject. No doubt there is a tendency on the part of teachers to cultivate the intelligence of the child rather than to secure for him those habits which will place his daily conduct within the limits of good personal hygiene. However, the force of the supervisors and of the superintendent is thrown upon the side of practical results. And through the efforts of many of the teachers a distinct impression has been made. While not so evident, this is true even in sections of the city which receive large and frequent installments of unprepossessing foreigners. An example showing definitely the way in which one of these matters is treated will render the general statement more forcible. In the course in physiology and hygiene the properties, preparation, mastication and digestion of food receives attention. But the matter does not rest here. Three schools are established and more are recommended in the superintendent's report, in which the girls of the seventh and eighth grades, who desire them, are given thirty lessons in practical cooking. Several visits to these schools have rendered me one of their enthusiastic champions.



The jovial doctor is always welcome, and any day you will call at Hicks or Outhwaite or Wade Park schools a dozen enthusiastic little cooks will prepare and serve you a lunch which will not only render you a firm friend of the cooking schools, but will convince you that the teaching of hygiene is becoming more practical.

#### HYGIENE OF INSTRUCTION.

This subject is so large, so complex and so difficult to treat that it is impossible in a paper of this nature to do more than merely to refer to the matters to which it relates. At least fifty pages of typewritten matter would be required for its proper presentation. It would discuss the physiology of brain work, school age, amount of study, home study, arrangement of work, number and length of sessions for work, recesses and exercise and recreation periods. It would refer to school excursions, vacations and holidays, vacation schools and colonies. It would argue the matter of discipline and punishments. Individuality, examinations, number of pupils to the teacher and regularity of attendance would all claim attention. The course of study in its hygienic relations to multiplicity of studies, methods of instruction, and to individual branches such as reading, composition, spelling, writing, arithmetic, geography, language, hygiene, exercise, physical education, industrial or manual training, in its hygienic relations to all of these matters a course should be examined and approved by an expert superintendent of instruction. Let him who essays to criticise an educational system first inform himself upon all of these topics. Let him familiarize himself with the school courses in vogue. Then let him watch their effects upon the health of pupils and teachers for a number of years and he will have arrived at the place where he will be at liberty to think upon these things. But if he values his reputation as a scientific man he had best not express himself too freely until experience has correlated some of his knowledge. Even then he may not be too dogmatic.

The course of study in use in the Cleveland schools is printed and can be obtained at school headquarters at any time. 'Upon study of its contents I am inclined to think that we would not find any subject taught which the most of us would wish to discontinue. Possibly the relative amount of time devoted to different branches would cause some discussion. In good buildings in the rooms of good teachers it works wonders.

I am convinced, however, that the children would succeed just as well as they now do if five minute periods of vigorous, wholesome, pleasurable exercise followed each recitation which calls for the close, prolonged exercise of the attention. In order to do this it would be necessary to take a small amount of time from subjects which now receive half an hour or more a day. In addition it seems to me that the regular exercise period should be doubled. Ten minutes a day is such a short period that it is very difficult to induce the average teacher to take the children to the halls and the yards for exercise. This slight change, together with closer supervision in physical training would accomplish most valuable results in preserving the health of both teachers and children, and I believe that it would not only not interfere in the least with the work along other lines, but that with this change the children would do better school work in other branches. Not only so, but at the end of the course the physical development and training would be of great worth to the children.

#### PHYSICAL EDUCATION.

Gymnastics.—Ten minutes a day is devoted to this branch in every grade below the high schools. From the hygienic standpoint curvatures of the spine have to be kept constantly in mind in using this ten minutes. Other considerations are the circulatory and respiratory systems and recreation. During each day deep breathing exercises are practised. Several times during each exercise period they are thoroughly taken while attention is paid to the ventilation, the air in the room being thoroughly changed. Any teacher who does not attend to this matter violates strict orders. In no case are gymnastics considered thoroughly good which the average child does not like. They should serve as recreative periods, and if they do not do so it is because the teacher is unskillful in this branch.

Play.—The spirit of play should enter into all physical training work. In games in the rooms, halls and schoolyards it receives some encouragement. On the whole the amount of this encouragement has been increasing.

Home Exercise.—During the past two years some of the teachers who are specially interested in the subject have encouraged their children to exercise at home. Some use systematic exercises and others have an attic or other play room fitted up and play games. Some children are thus being educated to take the

matter seriously, considering exercise a part of their daily regimen. In some cases small recreation clubs have been formed.

Games.—To a limited extent (very limited) these have been encouraged in the schoolyards. The grounds are so filled with pupils during recess that the principals find it extremely difficult to have games without accidents. A small pamphlet for the use of upper grade pupils has recently been published. It contains a description of ten games. The majority of the children of the city do not know and consequently do not play games which are of real physical benefit. Such games as are used are of little worth. At present no apparatus for games or exercise in any form exists in any of the school yards. We have \$500,000 worth of play grounds which yield but a minimum result in the development, training and health of the children. The grounds should be stocked with apparatus and special teachers in this branch should introduce and instruct the children in many wholesome forms of activity.

High Schools.—At these little is undertaken at present. The new buildings contain rooms which will be used for gymnasiums. The older buildings need halls which can be used for gymnasiums and several special teachers should give the high schools their entire time and attention.

#### SCHOOL GROUNDS.

Sites.—In school lots, and improvements on the same the city auditor's report indicates that the city owns property worth \$931,392. This does not include headquarters. The number of lots given on the building list is 73, the average value per lot being placed at \$12,759. Six of the lots upon which the new buildings stand are comparatively large and are valued at an average of \$8,670.50. This is \$4,088.50 less per lot than the average valuation of school lots. As the city grows these new lots will increase in value just as did the older ones. It looks as though the purchase of school lots is about as good an investment for the city as is the investment in park lands. To my mind the two should go hand in hand. The yards should be small parks or the schools should be in or near the parks. Heretofore we have made parks largely for adults. We are approaching the era in school yard and in park equipment when the needs, the education and the pleasure of the children will be the main considerations.



Soil, Drainage and Surface.—In the sand of Cleveland little trouble is experienced in the matter of soil and drainage. But the surfaces of parts of many of the yards are anything but conducive of play. Stones, ashes, cinders and broken glass strew the surface, much of which is too uneven for play ground purposes. Others contain good sand, but the surface is too soft and becomes extremely dusty. Either the property should be improved, giving to all of the grounds good surfaces and apparatus for physical exercise or it should be sold, except such as is necessary for the buildings and the money spent for such improvements for the buildings as good assembly rooms and gymnasiums. Few would advocate the second proposition. But a few thousand dollars spent upon the surfaces and in play ground apparatus would render the property a dozen times more beneficial. However, at twenty-one of the buildings the surface of the play grounds is in very good condition and they are used to a considerable extent by the children in their play.

Noise.—Twenty of the yards containing school buildings have car lines on one side of the lot. During the warmer weather the windows must be open more or less and the noise of the motors interferes materially with the work of the schools in all of the rooms on the sides of these buildings nearest the car lines. It not only renders it extremely difficult for the pupils to hear, but it is very hard on the voices of the teachers and supervisors. While many of these sites were selected before motors were dreamed of, their presence in these noisy locations serves to emphasize the principle that all school sites should be on quiet side streets or else that a school building should be placed in a large lot and on the part of the lot furthest removed from the street.

Arrangement.—Usually the main building is placed near the front of the yard in a position analogous to that of the ordinary dwelling house. Immediately in front of the building is a lawn. Many of these contain trees, flowers and shrubs and are kept in good condition by the custodians.

Twenty-six of the yards contain annex or relief buildings. Some of them contain both. The relief buildings can be removed, but most of the annex buildings will continue to occupy a large portion of the play ground and their walls will continue to darken some of the school rooms. They have been built by the board, I understand, because the rooms simply had to be provided and the school funds were entirely too small to admit of the purchase of new sites.

Area.—If the yards are to be used for play grounds they should be larger rather than smaller and the relief buildings should be taken from the older lots. The cooking and manual training schools should be placed in the main building.

#### BUILDINGS.

The value of our buildings, and their improvements, is set down in the auditor's report as \$3,203,428. This values the rooms at about \$4,000 each. But it does not include the value of land, its improvements or furniture and fixtures. It speaks well for the board of education and the director when we find that the 102 rooms in the six ward buildings of recent construction have an average valuation of \$3,976.86. And this is the total cost to the city, including land, improvements, building and furnishing. These are the best rooms in the city. The buildings are all situated in large yards (as school yards go), are the best in the city and are really good buildings. In order to provide sanitary rooms for the children and reduce the average attendance to forty pupils to the teacher we should erect twenty such buildings. Rooms are needed in order as follows:

To take the place of basement, store and relief rooms.....	143
To reduce the average attendance to forty pupils per room (approximately) .....	100
To provide for the increase in school population (approx- imately) .....	40
Total .....	283

This means that within the year over \$700,000 should be spent for buildings in order that all of the children in the grade schools shall have good school rooms and that some of the over-crowding be abolished by reducing the average number of pupils to forty to the teacher. In addition to this the interiors of several of the old buildings need to be entirely remodeled. Leaving out of account basement and relief buildings, fourteen of the older buildings contain rooms which are not well lighted. Some of these can be remedied through the use of prismatic glass. In others additional windows must be placed. In addition to more rooms for grade pupils additional buildings for high and industrial schools are very much needed.

## ROOMS.

The majority of the rooms in the buildings are good. Those in the new buildings are delightful. Approximately 280 new ones are needed *now* for the grade schools. Their addition would work a revolution in the schools.

## FURNITURE.

Seats and Desks.—With the exception of a few partially adjustable seats and desks in the new rooms, the furniture is antiquated and incorrect. But it is valued at \$268,887, and as long as a million dollars is sadly needed for building purposes it is not likely that it will be changed. The principles which underlie the construction of hygienic furniture are known, although they are not well applied in this country. We should be experimenting with this matter and as soon as really practical furniture can be manufactured it should be introduced into all of the new rooms.

## VENTILATION.

Temperature.—This is recorded frequently in all of the rooms. For the most part it is one of the matters dependent upon the teacher. In some of the buildings, however, the ventilating system is of such a nature that if a teacher opens windows, even for a few moments, she may disarrange the entire ventilating system of the building. It is needless to say that this is entirely unsatisfactory. It is apparent that the teacher must govern the conditions within her own room and she must know how and what to govern if the ventilation is to be good. On the whole improvement has been made in this matter from year to year. The new buildings are superior in this as in every other regard. All such matters, however, require constant supervision.

## SEWERAGE AND CLEANING.

As regards plumbing, the new buildings are well equipped. Some improvements in a few of the old ones would be beneficial.

It has been the custom to use the dry method in cleaning the buildings. Whatever additional expense is incurred by the wet method should be provided for and *it should be introduced at once*. As it is the halls are often filled with ancient dust which not infrequently finds its way into the lungs of the pupils and teachers. The dry method should be superseded.



## CONCLUSION.

Thus, in brief and imperfect manner, some phases in which improvements are being made as well as some of the demands of school hygiene within our public schools have received mention.

In this connection it should be remembered that the majority of the rooms in the city are good and that as a whole the children are under better sanitary conditions at school than at home. That even with the rooms overcrowded the great majority of the principals and teachers, through hard work and strict attention to business, secure admirable results so that the product of the schools for good far outweighs the product for evil. Let us not forget that most of the evils which the unthinking charge to the school system are not incident to the system, but to the lack of resources with which to render it operative. Grade and high school buildings, additional teachers, all these are greatly needed. The present demand, stated more specifically calls for some twenty ward buildings containing not less than 280 rooms. An increase of the teaching force for next year of not less than 150. An increase in the supervising force. (It is scarcely larger than when the school attendance was half its present size. Yet all admit that the supervision should be much closer than it can possibly be with the present force.) The director's office also should contain a sufficient number of assistants to enable it to perform its functions with dispatch. Additional high and industrial schools should be provided. But whenever we speak of improvement we are met with the question, "Can we do it with all of these basement and relief rooms still in existence?" And we have to answer, no! Judged by our own standards we are about a million and a half in arrears. Were we as ambitious as is New York we would not be satisfied with less than three or four millions. Private patrons, the state, municipalities, are pouring millions upon millions upon the altars of education, well convinced that it pays. Shall we allow thousands of our Cleveland children to remain in rooms which were never intended for school rooms and are simply the makeshift of necessity? Shall we continue to ask our teachers to care for and educate fifty pupils in such places when forty pupils is a large number for a good teacher in a good room? From the superintendent down the teaching force has been making a desperate fight to maintain the standing of the Cleveland schools. Shall the resources to provide the proper conditions for successful effort be withheld until we fall hopelessly behind in the

matter of public education? Or will those who are the friends of the schools support legitimate measures for their relief?

Through the efforts of the board of education considerable money is now in sight. Sufficient, I understand, to furnish ninety rooms for grade schools, build a high school for the west side and supply all needed equipment. But if our schools are to be thoroughly sanitary, conserving the health of pupils, and at the same time realize our educational ambition, they demand not only what may come to them through future appraisements, but a sufficient amount so that all needed buildings can be erected and at the same time these minor problems can be taken in hand and then, within a few years, they can, for the most part, be solved.

Hence, while we may subject the schools to fair and friendly criticism, eliminating that which is bad and introducing or improving that which is good, do not let us sidetrack. The startling need of the schools to-day is not criticism but CASH.

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## LIGATURES AND SUTURES IN ABDOMINAL SURGERY.

BY HUNTER ROBB, M. D.

Professor of Gynæcology, Western Reserve University; Gynæcologist-in-Chief to Lakeside Hospital, Cleveland, Ohio.

No subject is of greater interest to the abdominal surgeon than the selection of his ligature and suture material. An ideal substance for the purpose must permit of perfect sterilization; it must be durable, not readily infected, and relatively inexpensive. If catgut could be prepared in such a way that all suitable thicknesses of it could be thoroughly sterilized, and yet remain strong enough to stand the amount of traction necessarily employed in tying large vessels and masses of tissue, we might then have an ideal suture material. From an experimental standpoint, as well as from practical clinical observation we are only too well aware that this is not always possible. In abdominal surgery we cannot, therefore, as yet employ catgut exclusively, but must depend to a great extent upon silk, silver-wire and silkworm-gut. Catgut is cheap; it can be easily tied and within a short time becomes completely absorbed. Unfortunately, too early softening and actual absorption of the suture may take place before the tissues approximated have united sufficiently well to hold.

There are several modes of sterilization advocated, of which the cumol method is probably the best, if the sterilization is to be done by the surgeon. So far as our clinical experience goes, we have obtained good results with the catgut contained in sealed glass tubes prepared by Kiliani, Van Horn and St. John Leavans, of New York. With chromicized catgut the only criticism we have to offer is that in using the larger sizes we have found that in some cases the suture did not become absorbed, but gradually worked its way to the surface and was cast off. Not infrequently a drop or so of pus will be present in conjunction with this shedding of the suture, or a small amount of sanious fluid may escape. Recently we have abandoned the use of chromicized catgut and have returned to the use of silver wire for bringing together the fascia in closing the abdomen, and it is worthy of note that in no instance in which the silver-wire was used, have we had any infection of the wound. It is a great mistake to buy large quantities of catgut wound upon reels, with the ends of the sutures passed through a diaphragm below the stopper, as it is almost impossible to prevent contamination of these ends and consequently of the whole stock. It is far preferable to open one or more of the sealed tubes, which contain only a small quantity. In this way we may feel sure that the material is reliable, even if the cost be somewhat greater.

*Silk.* Chinese silk twist is easily sterilized in the Arnold steam sterilizer, the autoclave or by means of boiling water. Four sizes are employed: No. 3, quite fine, for intestinal sutures and for carriers for the needles; No. 4, for use when greater strength is required, as in suspension of the uterus and the ligation of small pedicles; No. 6, for tying off (the majority of) ovarian pedicles; No. 7, very heavy, for hysterectomy or when large masses of tissue have to be ligated.

*Silver-wire* we use as a buried suture in uniting the abdominal fascia. It has been proven that the metal exercises a direct germicidal effect. The suture remains buried in the tissue, rarely causing any trouble, providing that the cut ends be properly turned down so as not to scratch the skin. Silver-wire can be easily and thoroughly sterilized by being boiled in water.

*Kangaroo tendon* is warmly advocated by some operators, but is difficult to render sterile and is not so satisfactory as other ligatures.

Our methods in using these ligatures in abdominal surgery is to employ medium-sized silk for the pedicles in removing the



tubes and ovaries, and catgut for ligating the small vessels or bleeding surfaces. For suturing the torn intestine, we use fine silk; except when it is simply the superficial tissues that have been injured. Wherever we ligate small portions of tissue we use catgut.

In only one instance have I had to remove a silver wire ligature. Here we were led to believe that the infection was not due primarily to the silver-wire, but to the catgut which we employed in approximating the skin incision. In a series of 114 consecutive cases without a death we have had only four skin infections, and there has been only on infected pedicle. In closing the abdominal wound we employ a continuous catgut for the peritoneum, silver-wire for the fascia, and catgut for the subcuticular stitch; with this procedure, so far as our experience goes, the wound, as a rule, heals up without any infection whatsoever. In the four instances in which the skin incision became infected, we had used the chromicized catgut for bringing the fascia together.

Following is the list of 114 consecutive sections without a death, in which the above methods were employed. All the operations but one were performed in Lakeside Hospital:

Appendicetomy .....	24
Colporrhaphy, anterior .....	2
Dilatation and curettement .....	67
Dilatation with vesical balloon (under anesthesia) ..	1
Fibro-adenoma of breast, removal of.....	1
Hemorrhoids, removal of .....	2
Herniotomy .....	3
Hysteromyomectomy .....	3
Igni-puncture of ovaries.....	36
Myomectomy .....	7
Omentum, resection of portion of.....	5
Ovaries, resection of.....	15
Pelvic adhesions, separation of.....	46
Perineorrhaphy .....	17
Peritonitis, tubercular, drainage.....	1
Removal of cervical polyp.....	1
Removal of piece of cervix for diagnosis.....	1
Salpingectomy (single) .....	6
Salpingectomy (double) .....	1
Salpingo-oophorectomy (single) .....	24
Salpingo-oophorectomy (double) .....	46
Sebacous adenoma of labium majus.....	1
Suspension of uterus .....	42
Trachelorrhaphy .....	8
Vaginal puncture .....	1

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Total number of individual operations..... 361

The total number of individual operations greatly exceeds the actual number of patients from the fact that a single patient often presented several distinct pathological conditions.

Total number of cases in which abdomen was opened,	114.
Abdominal operations alone .....	56
Abdominal and plastic operations combined.....	58
Appendix vermiformis removed .....	24
Adherent vermiform appendix separated.....	6
Myomectomies .....	7
Myomatous tumors removed in above myomectomies	16
Suspension of uterus with separation of light adhesions (this case was operated on under cocaine anesthesia) .....	1

## THE CITY MORTALITY OF 1899.

BY H. E. HANDERSON, M. D., CLEVELAND, O.

The number of deaths reported to the health office in this city during the year 1899 was 5,556, an increase of 516 over the number reported in 1898, and the largest number reported in a single year since 1894.

The annual number of deaths and the estimated death-rate per thousand for each of the last seven years is given in the following table:

Year.	No. Deaths.	Rate.
1893.....	5,261	18.15
1894.....	6,663	17.43
1895.....	5,167	15.89
1896.....	4,859	14.71
1897.....	5,007	14.30
1898.....	5,040	13.62
1899.....	5,556	14.06

The population of the city for 1899 was estimated by the health office at 395,000, a round number which probably somewhat exceeds the *real* number of inhabitants, though the exaggeration is, doubtless, insufficient to alter more than the decimal figures of the death-rate. Happily the twelfth U. S. census, now impending, will supply us with a more trustworthy basis for future computations.

The total annual mortality for 1899, classified by months and by physiological systems, was as follows:

Month	Fevers	Nervous System	Respiratory System	Digestive System	Circulatory System	Urinary System	Generative System	Violence	Unclassified	Total
January...	81	116	193	40	52	38	2	17	72	611
February..	43	92	164	35	43	23	5	15	65	485
March....	40	89	187	35	36	28	3	17	66	501
April.....	31	112	145	35	49	19	1	27	83	502
May.....	24	83	107	47	48	20	2	26	74	431
June.....	22	79	86	49	41	16	6	37	58	394
July.....	15	103	76	140	41	23	2	33	90	523
August....	19	85	92	115	26	26	1	22	71	457
September	32	81	93	74	33	11	5	33	50	412
October...	42	72	93	50	32	21	1	21	75	407
November	35	61	102	30	34	14	5	20	84	385
December.	29	66	128	35	46	19	2	25	98	348
Total.....	413	1039	1466	685	481	258	35	293	886	5556
Per cent...	7.4	18.7	26.4	12.3	8.6	4.6	0.60	5.3	16	

For reasons given in my last report upon the mortality of the city very little reliance can be placed upon these figures except in the most general way, as indicating roughly the comparative mortality from the various classes of disease indicated. The classification of causes of death still in vogue in this city is too absurdly incorrect and imperfect to merit serious consideration of its numerical results.

It is to be hoped that our health officer, with the opening of a new century, may see his way clear to the adoption of the Bertillon classification of the causes of death, now adopted in several cities of the United States, and on the continent of Europe, and thus relieve his office of the stigma of its present irrational and even ludicrous catalogue of human ills. Our old acquaintance, spina bifida of the respiratory system, might at least be relegated to the pathological curiosities of the departing century.

The fact that about one-sixth of our decedents choose to shuffle off this mortal coil in ways defying, or at least escaping, classification, may be somewhat flattering to our ingenuity and originality. That no less than 248 of our citizens died of "senile debility" is equally flattering to our climatic advantages. Our budding civic enthusiasm is, however, rudely dashed when we read that in the 365 days of the departed year 364 citizens of a



city which can justly pride itself on the frequent senescence of its inhabitants, perished ignominiously of "inanition"—mother's milk, sterilized milk, modified milk, peptonized milk and the whole list of baby foods notwithstanding. Manifestly

"Something is rotten in the state of Denmark."

Of the 5,556 deaths within the limits of the city, 1,700 occurred on the west side of the river and 3,856 east of that stream. The populations of these two divisions of the city are assumed by the health office to be respectively 128,174 and 266,826. The corresponding death-rates are therefore 13.26 and 14.45 per thousand, rates which reveal a striking difference in the sanitary conditions of the east and west sides of our city. The corresponding rates for the preceding three years were as follows:

Year	E. Side	W. Side	Difference
1896	15.27	13.53	1.74
1897	14.65	13.58	1.07
1898	13.80	13.25	0.55

It will be seen, therefore, that during the entire period of four years to which this investigation has been limited, the west side of the city has enjoyed better sanitary conditions than its associate east of the Cuyahoga river. Doubtless much of this advantage is due to the comparative absence on the west side of foci of crowding, poverty and intemperance, not infrequent in the eastern section of the city.

The mortality from the so-called zymotic diseases during the past year is shown in the following table:

Small Pox.....	2
Measles.....	2
Scarlet Fever.....	36
Diphtheria.....	142
Whooping Cough.....	22
Diarrhoeal Disorders.....	265
Typhoid Fever.....	120
Cerebro-spinal Fever.....	31
Total.....	620

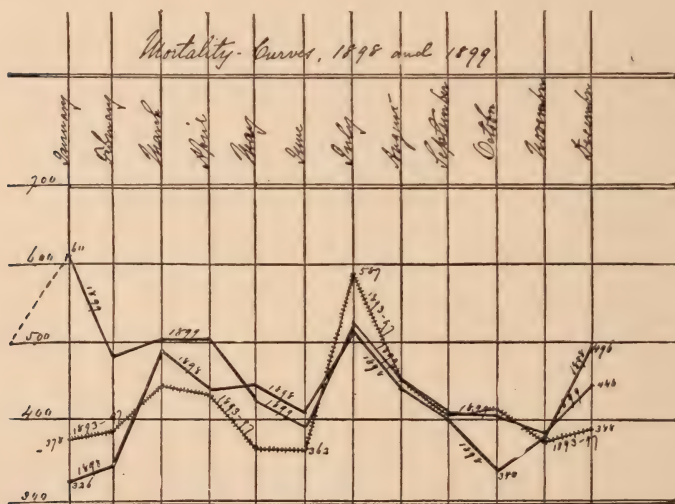
This total is 35 less than in the same table for 1898, the principal decrease being found in the mortality from diphtheria and diarrhoeal diseases, of which the former in 1898 occasioned 161,

and the latter 289 deaths. The zymotic death-rate of the city in 1899 was 1.57 per thousand. For the preceding three years the zymotic mortality rate is exhibited in the following table:

1896.....	2.6
1897.....	2.03
1898.....	1.77

It is manifest, therefore, that the increased mortality of the past year was not occasioned by any unusual prevalence or virulence of the ordinary zymotic diseases.

On examining the mortality curves of the years 1898 and 1899, as given below, it will be observed that the curve of 1898 manifests a sharp rise in December, which culminates in January, 1899, and does not return to the normal level until May of the last mentioned year. This sharp ascent marks the effects of an epidemic of influenza, or la grippe, which appeared in November, 1898, and displayed its fatal influence until late in the spring of 1899. It raised the monthly average of deaths from 420 to 519, and cost the lives of more than 500 of our citizens.



The number of deaths in children under the age of 5 years in the year 1899 was 1,996, or 36 per cent. of the total mortality at all ages. The deaths of infants under 1 year of age were 1,424, or 25.6 per cent. of the total mortality. These proportions are about the same as observed in preceding years.

A table of the comparative mortality rates in the lake, river and upland wards of the city for 1899 is given below:

Wards	Population	No. Deaths	General Rate	Zymotic Rate	Standard Rate
Lake.....	46,079	702	15.23	1.84	13.39
River .....	85,676	1,170	13.65	1.29	12.36
Upland.....	263,245	3,684	13.99	1.61	12.38
City .....	395,000	5,556	14.06	1.57	12.49

It will be observed that the river wards, as in the similar table of 1898, display the lowest rate of mortality, both general and zymotic, and that the lake wards manifest the highest. Further observation will be required to show whether these peculiarities are permanent or merely transitory.

The statistics of the four wards displaying the highest rates of mortality during the past year are furnished in the following table:

Wards	Population	General Rate	Zymotic Rate	Standard Rate
13th Ward.....	6,721	30.50	2.08	28.42
28th Ward.....	4,828	22.78	1.65	21.13
1st Ward.....	7,532	22.30	2.52	19.78
3rd Ward .....	2,946	20.70	2.03	18.67
City.....	395,000	14.06	1.57	12.49

For purposes of comparison I give the similar table extracted from my report for the year 1898.

Wards	Population	General Rate	Zymotic Rate	Standard Rate
13th Ward.....	6,435	24.86	1.24	23.62
1st Ward.....	7,378	23.72	4.20	19.52
28th Ward.....	4,408	21.32	3.85	17.47
City.....	370,000	13.62	1.77	11.85

It will be observed that in both tables the same three wards preserve the unenviable notoriety of being the most unhealthy wards in the city. And this unsavory pre-eminence has been maintained unbroken for the four years during which my observations have been continued. The situation and the general char-



ater of the population of the First and Twenty-eighth wards serve largely to explain the excessive mortality of these wards. But no such explanation seems applicable to the Thirteenth ward. Bounded by Central, Scovill and Willson avenues and Perry street, the Thirteenth ward is an upland ward, not excessively crowded, containing no excessive proportion of young children, inhabited by a generally temperate and industrious community, and surrounded by some of the healthiest wards in the city. I know no reason to presume that its population has been underestimated; and yet for the past four years its mortality rate has averaged more than twice that of the city in general. In concrete figures the excessive mortality rate of the Thirteenth ward in 1899 alone indicates the apparently needless sacrifice of 110 human lives—a holocaust which, if occasioned by what we call “accident,” would have demanded a stern reckoning with those responsible for the disaster. It is true that this ward in 1890 contained one-seventh of the entire negro population of the city. We know also from experience that the mortality rate among negroes is considerably higher than among whites. Yet it scarcely seems credible that the negro contingent of the population of the Thirteenth ward, a contingent which cannot exceed at most one-tenth of the entire population, should suffer a mortality sufficiently excessive to more than double the mortality rate of the entire ward. At all events, the excessive mortality of the Thirteenth, Twenty-eighth and First wards opens a broad field for the labors of our sanitarians and philanthropists.\* The high mortality rate of the Third ward, observed this year, seems to be only exceptional and explicable, probably, by transitory conditions.

\* Since the above was written the explanation of the apparently excessive mortality of the 13th ward has been revealed. Two years ago it was suggested to me that the high death rate of this ward might be due to charging to the ward itself the deaths occurring in certain public institutions within its limits, and especially that of the St. Ann's Infants Asylum and Maternity Home on Marion St. In order to determine this point I wrote to the then health-officer, asking what was the custom of his office in charging the deaths which took place in the public institutions of the city. He replied that the deaths of decedents in the public institutions were invariably charged to the wards in which such decedents resided on entering the institutions. A recent conversation with our present health-officer, however, establishes the fact that deaths occurring in the St. Ann's Infants Asylum have heretofore been charged to the 13th ward, without remark or explanation. As of 33 deaths charged to this ward within the the last three months, 19 occurred in this asylum, the magnitude of the statistical error incorporated in the reports is apparent. In a maternity home and foundling asylum it is manifestly impossible to follow strictly the usual rule of the health-office in dealing with public institutions, but the absurd injustice of charging the results of the sins of the entire community to the unfortunate 13th ward is equally glowing. I hasten, therefore, to apologize to the 13th ward for the unjust suspicions cast upon its sanitary character in my several papers upon this subject. They were the natural result of doubtless honest, but equally fictitious and misleading, statistics issued by the health-office.

A pleasant contrast with the foregoing tables is found in the tables which immediately follow, and which furnish the statistics of the four wards whose mortality during the past year has been the lowest of any wards in the city:

Wards	Population	General Rate	Zymotic Rate	Standard Rate
16th Ward.....	10,850	8.50	0.28	8.31
42d Ward.....	8,281	9.90	0.96	8.94
32d Ward.....	6,422	10.90	1.24	9.66
22d Ward.....	13,518	11.09	1.33	9.76

It is, perhaps, worthy of remark that the banner ward of the city during the past year, at least in the point of view of general mortality, the Sixteenth ward, is located upon the banks of the Cuyahoga river, immediately adjacent to the First ward of unsavory reputation, is densely populated, unclean, and inhabited largely by Jews.

Directing our attention now to individual zymotic diseases, we find that, in spite of the unusual prevalence of small-pox during the past year, this disease occasioned only two deaths in the city, one in the Fourth and one in the Sixth ward.

Measles was responsible likewise for only two deaths throughout the entire city, while the far less dreaded whooping-cough occasioned a mortality of twenty-two persons.

Scarlet fever was the cause of thirty-six deaths, scattered throughout twenty-one of the forty-two wards of which the city is composed. The largest number of deaths in any single ward was four in the Eighteenth ward.

Diphtheria was very generally diffused and occasioned one or more deaths in every ward of the city except the Fifth, Tenth, Fourteenth and Thirty-first. The largest number of deaths (12) from this disease is reported by the Nineteenth ward, to which the Twenty-third ward is a close second with 11 deaths. On the west side the Fortieth ward also reports 8 deaths.

Diarrhoeal diseases exacted their usual fatal tribute, from which two wards only were exempt, the Fourteenth and the Sixteenth. The Twenty-fifth and Twenty-seventh wards report the largest number of fatal cases, each recording 20 deaths from this class of diseases.

Typhoid fever occasioned one or more deaths in every ward of the city east of the Cuyahoga river, sparing also on the west

side only the Thirtieth, Thirty-second and Thirty-ninth wards. The greatest number of deaths (11) is reported from the Twenty-fifth ward. On the west side 7 deaths are also charged to the Thirty-seventh ward. The annual mortality rate from this disease for the entire city was a trifle over 30 per 100,000 of the population.

No specific figures as to the mortality from pulmonary phthisis during the past year are furnished by our reports. If, however, we combine the number of deaths ascribed to pulmonary tuberculosis, phthisis and pulmonary hemorrhage we find an aggregate of 493 deaths, which may, with considerable probability, be assigned to pulmonary phthisis. These figures yield a mortality rate for this disease of 125 per 100,000 of our population.

On the whole, with the exceptions already noted, we may say that the sanitary conditions of the city during the past year, so far as they are displayed in the rates of mortality, have been fairly satisfactory and merit the approval of the public and the medical profession.

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## PODALIC VERSION VS. FORCEPS DELIVERY.

BY D. S. HANSON, M. D., CLEVELAND, O.

Written for the Cleveland Medical Gazette.

We wish in this short article to contrast the advisability, greater safety and easy application of this method in certain cases where forceps are very commonly used with disastrous results to child and increased suffering, prolonged labor, and consequent danger to mother by forceps. The indications for forceps as given in an American text-book on obstetrics are :

1. In lingering labor where the natural efforts are unable to effect delivery.
2. Where speedy delivery is imperative in the interest of mother, as in hemorrhage, convulsions, exhaustion, advanced heart or pulmonary disease.
3. When speedy delivery is indicated in the interest of the child, as in impending death of mother or threatened asphyxia of the child.

The same authority says, "the head presenting it *should be engaged in pelvis* (italics mine) ; it should be of normal firmness and proportionate in size to the parturient canal, and there must



be no mechanical obstacle to delivery that requires great force to overcome, and the os should be dilated or dilatable."

The operation is divided into the *high, medium and low.*

The former being the only one that concerns us here, is when the head is in or at the brim, but has not yet descended into the excavation.

Version is classified as the *external bipolar* and *internal* operations, and the latter is usually podalic, and it is this method we wish to contrast with the high forceps operation.

Indications for this form of version are, "where there is a transverse position, usually a shoulder, in normal pelvis where head presents when life of child or mother is threatened, where the head cannot be induced to engage and where the cervix is not sufficiently dilated so that forceps can be applied. This indication includes placenta previa except in the comparatively simple marginal variety with head low in the pelvis and scant bleeding. It also includes cases of prolapse of the cord not otherwise manageable. In certain cases of prolapse of one or more extremity and chiefly when a foot presents, podalic version is our only resource, also in the more troublesome face or brow presentations with the head at the inlet, when the position of the head cannot be rectified manually, and particularly in posterior positions. Lastly in certain other emergencies, should the case call for rapid extraction we employ version as in accidental hemorrhage or eclampsia. In the flat pelvis when the true conjugate is below three and one-half inches, when there is a relative disproportion between head and pelvis, when the head does not engage and changes its position frequently above the brim, or where previous breech deliveries have terminated more favorably than vertex positions, also in obliquely contracted pelvis and unsuccessful or unfavorable engagement of head with the occiput over the contracted side."

The contra-indications are, "rigid and permanent contraction of uterus, especially in dry labors, high position of contracting ring, two to three inches above symphysis, impaction of the presenting part which would require dangerous pressure to dislodge."

Being fully aware that the improvements made in obstetric forceps in the last few years have made them more available for high application (it is well to remember that high operation does not mean a head so high that it is freely movable above brim), yet we believe their usefulness here has been greatly overestimated,

and many a child has been sacrificed by the delay incident to their use and failure where version has been successfully done afterwards with loss of child which might have been saved had version been first resorted to.

Theoretically, the axis traction forceps will follow pelvic curve, but practically the symphysis is impinged upon to such an extent that it constitutes a real obstruction and will greatly impede delivery if not make it impossible, furthermore this form of instrument has a well established reputation for slipping and thereby fracturing skull of child.

In version the dangers to mother and child must be kept sharply in mind. The former are, rupture of uterus (which is not at all likely to occur unless liquor amnii is drained away with uterus firmly contracted around child), sepsis (which should be avoided in nearly every instance with proper cleanliness and disinfection), shock, hemorrhage and lacerations. To the child the dangers mainly are interference of circulation by pressure on cord, embarrassment of respiration by attempts of child to breathe before head is delivered, thereby drawing fluids into lungs, injury to nerves by too much traction on neck, and fracture of humerus in efforts to get down arms, the latter are usually forced up by an insufficiently dilated cervix or else by too rapid delivery before uterus has time to contract down on undelivered portion of child.

In prolapsed cord podalic version, in my hands at least, has been more satisfactory than any other method, and I would strongly advise it in this condition to the exclusion of the ineffectual procedures so frequently resorted to.

In many cases where labors have been very tedious and prolonged, lasting sometimes even for days, with finally difficult forceps delivery, there may be saved an immense amount of suffering by doing podalic version under an anaesthetic as soon as the cervix is sufficiently dilated and before head is engaged or membranes ruptured. To illustrate, the following case is reported:

Ruth C., age 42, Multip., last child delivered nine years ago, always had labor pains from two to four days with previous six labors, being obliged to walk the floor during entire time; she looked upon the present ordeal with the utmost dread, for last confinement was worst of all, forceps being used after three days of suffering, it taking the attendant four hours to deliver a dead child. She said she sent for me because she had been present at a case where chloroform had been administered and version performed, and as that was the easiest confinement she had ever seen

she wanted me to do the same by her as I had done with the other case, and that was exactly the course pursued. I was called at 1 a. m., March 10th, of present year, and matters proceeded as usual until 4 a. m., when os was fairly well dilated and head above brim. Administering chloroform until surgical degree was reached, I easily turned and delivered, everything going to a favorable termination and not more than fifteen minutes taken for whole procedure. The husband could hardly believe his senses when he saw all so nicely and quickly terminated. When compared with forceps in like condition version has hardly more than one drawback, and that is some increased danger of sepsis, but as previously stated, with proper care that can be avoided.

1419 Broadway.

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## **Abstracts and Extracts.**

EXTRACT FROM PROCEEDINGS OF NEW YORK ACADEMY OF MEDICINE,  
SECTION ON ORTHOPAEDIC SURGERY.  
TREATMENT OF TORTICOLLIS.

Dr. Townsend presented a girl 12 years old who had been relieved of torticollis, the result of suppurative cervical adenitis at the age of 5, which had produced cicatricial adhesion to the left sterno-cleido-mastoid muscle. The head had been pulled over toward the left shoulder and the deformity had been increasing for four or five years. On Feb. 1, 1900, an open incision  $1\frac{1}{2}$  inches long, about 2 inches above the clavicle over the belly of the muscle, and free section of all the resisting structures, had relieved the deformity. The head had been held in the opposite position by plaster bandages. There had been no pain, the temperature had never been above 99 degrees and the wound healed by primary union. The result was satisfactory. The head was in good position with motion. A little gap was felt below the scar, but the muscle had probably united. Subcutaneous tenotomy would have been impossible as it had been necessary to carry the incision to a point where no one would have dared to go. In general he preferred the open incision for division of this muscle.

Dr. R. A. Hibbs commended the open incision. In a recent operation on a girl 5 years old, after section of the sternal portion of the muscle the deformity was only relieved by division of the clavicular portion through another skin opening.



Dr. R. Whitman practised the open incision in torticollis. Complete division of all contractions, correction of the secondary distortion by vigorous manipulation, fixation for a time in the over-corrected position by a plaster bandage and after treatment by proper exercises would secure good results without the subsequent use of apparatus.

#### SPONDYLITIS DEFORMANS.

Dr. Whitman presented a man 46 years old with a spine ankylosed excepting the occipito-axoid joints. Fourteen years before, a long and severe attack of inflammatory rheumatism had affected nearly every joint excepting those of the back. This and several milder attacks in the next nine years had been coincident with gonorrhoea, which had been absent the past five years, while rheumatism had involved the back and with a persistent "lumbago" the entire spine had become rigid. There was pain in the loins and under the shoulder blades, increased by walking and by jars. The patient was nervous and irritable and easily startled and felt as if the forehead were clasped by a tight band. His equilibrium was disturbed by the forward projection of the head and by the obliteration of the normal lordosis, so that he felt himself constantly inclined to fall forward, whether sitting or standing.

Dr. Elliott asked whether gonorrhoea was excluded as a cause.

Dr. Whitman did not know whether the so-called rheumatism which had involved the back was gonorrhoeal in its origin or not.

Dr. Elliott asked whether the deformity was bony or fibrous.

Dr. Whitman thought it was partly fibrous and partly bony, an ossifying periostitis. The spine was not entirely rigid as there was discomfort on changing the position, although motion could not be demonstrated. He intended to try suspension as an experiment.

#### HAEMARTHROSIS OF THE KNEE.

Dr. Hibbs presented two brothers, aged respectively 11 and 15 years. There was marked effusion and limitation of motion, without reflex muscular spasm, in both knees of the older boy and the left knee of the younger. The swelling was marked. The patients were first seen in July, 1899, two weeks after the older had a hæmorrhage from the lips accompanied by what was evidently an acute hæmorrhagic swelling of both knees. Elastic knee caps were ordered with immediate comfort and the boys were not

seen again until recently. A feature of the history of each patient was that bleeding had occurred from various organs at intervals of one, two and three months, and that with each recurrence walking was rendered impossible by the tense and painful swelling of the knees. No other joint had been affected. Their father had died of some acute disease and their mother was living and healthy. The synovitis caused by the hæmorrhages had been prevented from resolution by their frequent recurrence. The effect of applying pressure would be observed and recorded.

Dr. C. A. Elsberg recurred to the case reported by him at the meeting of the section held on October 20, 1899. A boy 2 years old had hæmorrhage into the knee and three or four weeks later similar occurrences in three of the finger joints in a family in which the male children of healthy mothers had been hæmophilic. An elastic knee cap had been applied and the child was fed on gelatine for a while on a theoretical rather than on any other basis. The patient was seen once a month and the blood in the knee was gradually absorbed, leaving the joint in a practically normal condition. He would continue to wear the knee cap, removing it only at night. There had been repeated hæmorrhages under the skin, but no return of bleeding into a joint.

Dr. H. S. Stokes said that hæmophilia was generally transmitted through the mother to her male offspring, the daughters, like their mother, showing no sign of the condition, although their male children were almost certain to be hæmophilic. The recurrence of swelling of the joint did not necessarily indicate another hæmorrhage. A subacute or chronic synovitis was set up by the extravasation and more or less imperfect absorption. After a hæmorrhage treatment should be prolonged to promote and terminate absorption. The general treatment should receive attention and rest, immobilization, pressure, strapping and counter-irritation should constitute the local treatment.

Dr. Hibbs said that, if done, strapping would have to be continued indefinitely, as the knees in his cases were swollen all the time. The effect of one hæmorrhage did not disappear before the occurrence of another.

#### A RUBBER SPLINT SHOE.

Dr. H. J. Bogardus exhibited a hip splint which was shod, not with leather, but with a piece of the rubber tire in common use on the wheels of road vehicles. The tires were made in widths varying by  $\frac{1}{8}$  inch and in length about 13 feet, of which the waste

ends were suitable for this purpose. A piece could be cut off with a wet knife blade and fastened on easily and most securely by the ingenious and yet simple application of a couple of screws. In economy, durability and noiselessness the shoe commended itself.

#### ADDITIONAL MECHANISM FOR THE HIP SPLINT.

Dr. Hibbs exhibited a modified hip splint. The upright was a hollow rod constructed in the usual manner excepting that it reached the ground and ended in a foot piece suitably shod for bearing the patient's weight. It also had a slot on its inner side which permitted a sliding rod to carry a second foot piece, not shod, to which were attached the leather traction straps. The sliding rod had at its upper part a rack moved by the usual pinion or key, and at its lower part a veritable ratchet and spring catch. When the patient was recumbent traction was made by the key and secured in the usual manner, and when the patient stood the downward pressure of his foot on the movable foot piece took in the slack of the traction straps, the additional traction thus made being retained by the automatic action of the spring catch of the ratchet.

Dr. Whitman said that the arrangement was much better than the ordinary one, but a disadvantage was that the brace could not be made longer and therefore would be outgrown in a short time.

Dr. Hibbs said that when the upright of the ordinary splint was lengthened with the key it was thus weakened and had also to be replaced by a longer one.

Dr. Judson said that the additional traction gained when the patient was erect would prove to be too much when the patient lay down again.

Dr. Hibbs said that when necessary, which would not often happen, the extra traction could be relaxed by the attendant or the patient could loosen the buckles of the perineal straps.



# THE Cleveland Medical Gazette

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## Editorial.

### THE OHIO MEDICAL LAW.

After over twenty years of faithful and untiring work on the part of those of the medical profession of Ohio for an advanced standard in medical education, and especially on the part of the officers and members of the Ohio State Medical Society and its affiliated societies, we have at last a law of which we may well be proud. The strong features of the law are as follows: Whereas

in most other states there are separate boards for each school of medicine, necessitating one standard for the eclectic, one standard for the homeopathic, one standard for the regular, and giving no guarantee that these standards shall be uniform, but rather the contrary, in Ohio there is one board of which no school of medicine has a majority, in which all schools are represented, and which guarantees a uniformly high standard for all schools of medicine. Furthermore, the new law takes a long step forward in the matter of preliminary education; heretofore in this state, and in fact, in most states, the colleges were the judge as to whether a man had the adequate preliminary education, each college being a judge for itself. There has been great laxity in admitting a man to matriculation who had not the proper preliminary training. Under the new law the State Board determines whether a man has preliminary training with his medical diploma when he comes up for examination. He must also submit his literary credentials preliminary to the study of medicine—either a diploma from a reputable college granting the degree of A. B., B. S. or an equivalent degree, a diploma from a normal school, high school or seminary legally constituted, issued after four years' study (New York requires but three years), a teacher's permanent or life certificate issued upon examination by any State Board, a student's certificate for admission to the freshman class of a reputable literary or scientific college, or in default of one of these, he must pass an examination by the examiners, certified by our own State Board, none of which examiners shall be connected with any medical college. The examination is to be held simultaneously in Cincinnati, Cleveland, Columbus and Toledo, and the questions submitted to be uniform. After this preliminary education he must have received a diploma from a reputable medical college, or if he come from a foreign country he cannot, as heretofore, register on a diploma which gives no right to practice medicine in the country from which he comes, but he must bring with him a certificate which grants him the full right to practice all branches of medicine and surgery in the country from which he comes. Having this certificate he may come up for examination. The midwife, too, who under the old law was required to register merely, under the present law must also pass an examination before the board, thus paving the way to substitute competent midwives, as those who were allowed to register without proper education die off.

The definition of what constitutes the practice of medicine has been stiffened up so that it would seem that even a hostile supreme court could hardly find a conviction of the law to evade its spirit and plain letter. The exception which was made in favor of the Ohio students already matriculated will in the long run prove a disadvantage. The board has four years in which to establish its standard, with no attempt or pressure to temper the wind to the Ohio shorn lamb. Had the students of certain schools, egged on, by the way, by the faculties, not made this modification necessary in order to pass the bill, those same schools would doubtless have been found pleading for a low standard of final examination. As it is, they have nothing to say. When the question was up for discussion they said they thought they could get their students ready for examination in about four years, and the probability is that it will be for the benefit of the profession of the state that they have been given this leeway.

While the students were holding up the law the osteopaths got in their work, and had it not been for the strenuous efforts of the medical profession of the various districts of Ohio dealing with their own representatives, we should have failed. In fact, we would have failed as it was, had it not been for the masterly efforts of the Honorable W. F. Roudebush, who had charge of the bill in the senate. The osteopaths, aided by the Auditor of State and two judges of the Supreme Court who openly lobbied for the bill on the floor of the Senate, held up our measure until the next to the last day of the session. When it had passed the Senate with the amendments giving recognition to the osteopaths under the condition that they properly prepare themselves by four courses of five months in four separate years and pass an examination in anatomy, physiology, chemistry and physical diagnosis, the bill was mysteriously lost in its passage from the Senate to the House and was not re-discovered until towards the evening following, but a duplicate bill was ready for the signature of the President of the Senate. The bill was found again and passed the House with the necessary amendment. In the meantime, the osteopaths, taking advantage of the absence of the medical men from the House, who were attending the funeral of one of the members, railroaded a bill through the House creating an osteopathic board, with power to admit members without examination if they so chose, yet giving them the power to examine those whom they cared to examine. This bill was in the Senate and would have passed the Senate Saturday before adjournment if



within twelve hours the profession had not shown such a united front as to force the bill to be held over on the calendar and be lost in the unfinished business of adjournment.

But so long as we got it, it makes no difference now how near we came to losing it, and the sincere thanks of the profession is due not only to the official representatives of the State Society, but to the chairmen of the committees in the House and Senate, and also to Dr. N. R. Coleman, of Columbus, who has labored for many years to secure this legislation, and to Dr. Frank Winders, secretary of the board, who watched the attitude of the members and the proceedings on the floor of both House and Senate with a vigilance which contributed no small measure to our success.

L. B. TUCKERMAN.

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### THE JOINT NATIONAL LEGISLATIVE COMMITTEE.

For years the medical profession has been acting at cross purposes in respect to the measures that have come before Congress for action relating to sanitary questions and questions wherein the interests of the medical profession are especially affected. The American Medical Association would pass some resolution, some State Society would pass some other resolution, the Association of Surgeons would pass some other resolution, and all these resolutions would come before the Committee on Congress and neutralize each other. This has been appreciated for some time by those on the ground in Washington, and several attempts have been made to organize a body which should serve to bring about a degree of unity in the medical profession as a whole, so that when the profession appeals to Congress it should appeal as a united profession.

Last year at the American Medical Association a step was taken which bids fair to bring about this result. It was resolved by the American Medical Association to form a committee of three which should meet in Washington and which should invite to affiliate with it one representative from each state society,—these three and the delegates from the state societies to discuss questions pending before Congress, and come to some agreement and to refer their finding back to the several bodies, which they represent, for ratification. Thirty-two states responded to the invitation, and at the meeting a number of measures pending before Congress were discussed. On most of them they were ready for

action, but on some of them they concluded that action would better be deferred until a greater unity of sentiment could be reached regarding the advisability of the measures, but the most important recognition which they made was that the constitution of the American Medical Association, now consisting of the affiliated societies in the several states, should be so amended that the joint national legislative committee should be a prominent feature of our national medical polity.

There were four measures about which the committee gave their unqualified approval and which the Ohio State Society ratified at its last meeting in Columbus. These measures were: S. 4200, by Mr. Hawley, for the relief of assistant surgeons of the United States army, providing for their pay when off on sick leave, the same as regular surgeons of the line; S. 4274, by Mr. Hawley, provides for the appointment of assistant surgeons of volunteers at the rank of first lieutenant, and to promotion to captain after two years of faithful service; S. 559, by Mr. Cockrell, provides for the investigation of the pollution of water supplies, and S. 4171, by Mr. Vest, granting additional quarantine power to the marine hospital service in order to prevent the Cuban official fleet, which is now outside of our quarantine regulations, from surreptitiously landing yellow fever cases upon our Florida coast. It became apparent, however, when the Spooner bill, establishing a national health commission appointed by the president and confirmed by the Senate, that while the American Medical Association had endorsed the measure the state societies were by no means united in its favor, and it was recommended that the measure rest awhile and not be endorsed by the committee. The prompt discovery in this committee meeting of a serious difference of opinion with regard to the merits of this bill proved at once the value of it to the medical profession in its relation to the highest legislative body in the land. We have reason to feel gratified that it was the plan proposed by the Ohio State Society and the American Medical Association that has resulted in effecting an organization which has so long been felt a desirable—nay, a necessary need.

L. B. TUCKERMAN.

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#### A WORD OF GREETING.

The GAZETTE offers its congratulations to the medical graduates of this year, and wishes them all success in their chosen work.

It realizes the cost of mistakes made in the beginning of a medical career, and perhaps a few words of suggestion and advice may not be out of place at this time.

You have for three or four short years been *medical students*; you are now entering upon a course for life as *students of medicine*; in the past your work has been systematically planned and arranged for you by older and more experienced heads than your own—the road was straight and you had only to follow it; in the future you are to do your own planning, and will be left to hew out your own salvation unassisted.

During the period at the medical school you have undoubtedly learned to respect the judgment of many of your instructors, and are tempted to ask the advice of these gentlemen regarding a suitable place for location. However valuable their assistance may have been in the class-room, or their opinions prove on purely medical questions, they can be of little or no value on this all important matter you have now to decide. It is one thing to advise a class, but quite another to deal with its individual members, where the social and financial conditions, and the natural abilities and educational qualifications vary so greatly. A man must choose his location for himself, and the fewer he consults on the matter the less bewildered he will become. Nevertheless, there are a few fundamental truths that it is well to know.

In the first place, there are no openings in medicine; at least they are as scarce as hens' teeth. The profession is already overcrowded, and a man must make a place for himself. This a *good* man can do, but he cannot do it in a day, or a month, or a year. As a general rule a young physician becomes established much quicker in the suburbs—if he locates in a large city—than nearer the center of town, where he must enter more closely into competition with men of established practice and recognized ability.

The first thing in importance for the young practitioner is to enter the field fully equipped in a scientific sense, and toward this end the value of a hospital experience cannot be overestimated. Secure such an appointment if possible, and if not successful, try to get a connection as assistant to the physicians on dispensary service. Six months spent in a modern hospital will be worth ten years of private practice. Its value cannot be overestimated. Medicine is a science; its practice is an art, and you should all strive to become masters in it. The knowledge that will compel recognition, and lead you on to success, you have yet, in a large measure, to acquire. The education of the class-room and the lab-



oratory must be supplemented by a familiarity with the world and its people. The best of you, at present, have but a foundation, and the tools by which to build the superstructure. Take care how you handle them, for if not properly used some of them may become two-edged.

The honest exercise of perseverance, tact, diplomacy and enterprise will, in the next few years determine the type and kind of a physician you are to make of yourself.

Appear to be *just what you are*, for honesty pays in the long run, and you will be respected and admired for it. No physician is to be trusted who does not appreciate his own limitations. He who has unbounded faith in himself is either a fool or a knave, or perhaps a mixture of both. Be not, therefore, afraid of consultations—the best men in the profession are not—for they are far more an evidence of strength than they are a sign of weakness, and will invariably strengthen your position, unless, perchance, you have chosen some rascal with whom to confer. Indeed, there are occasions when it is the part of wisdom to request a consultation, even when there may be no real need of it. It always divides the responsibility; it usually relieves the anxiety of the family, and it not infrequently—especially in surgical cases—is a protection to the physician.

Do not make the mistake of neglecting the business side of your profession. No other class of men experience as much trouble and annoyance in collecting their accounts as physicians do, and it is largely owing to the laxity, shown by so many of them, in their business methods. Render your statements promptly, and educate your patients to consider the "doctor's bill" of as much importance, and therefore to be settled as promptly, as that of the grocer or the tailor. Success can be gained only by the combined exercise of a number of qualities, not the least of which is a business foresight. No man can make the most of himself, if he does not know where his next dollar is to come from, or if he is continually embarrassed by the grumbling of his creditors, and it is therefore incumbent upon him to adopt and follow good business methods, for it will make a vast difference in his income. It is not what a man *books*, but what he *collects*, that he is to live on. Many excellent physicians die poor, and leave their families in actual want, because they have never cultivated the habit of promptness in cashing their assets. It is your duty, both to yourself and to the profession, to place a just value upon your services,

and insist upon collecting the full amount, when your patients are in any position to meet the account.

Finally adopt as your watch-words: Rugged honesty; stable reliability; intelligent perseverance, and faithful endeavor, and if it is in you to succeed, you will.

G. SEELEY SMITH.

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## MEETING OF ALUMNI ASSOCIATION OF CLEVELAND COLLEGE OF PHYSICIANS AND SURGEONS.

The Alumni Association of Cleveland College of Physicians and Surgeons enjoyed the most enthusiastic and best attended meeting in its history, on the afternoon of May 2d at the Cleveland General Hospital. Dr. N. S. Everhard was temporary chairman in the absence of President Dr. A. G. Bruce, of Adrian, Michigan.

After the graduating class had been admitted to the association as members, a nominating committee was appointed as follows: Dr. N. Stone Scott, Dr. G. B. Woods, Dr. S. W. Kelley.

We then listened to the reports of the class historians. The first to respond was Dr. W. S. Haugh, class of '66, of Cuyahoga Falls, who gave us reminiscences of student days. The doctor being one of the oldest graduates of the Wooster College, and having a remarkably good memory, his talk was especially interesting to the younger graduates.

Dr. G. B. Woods, of Washington, Pa., class of '74, next responded. His paper will be published in the alumni catalogue.

The next to respond was Dr. A. D. Warner, of Burton, Ohio, representing the class of '75.

Dr. C. B. Parker then responded for the class of '77, dwelling particularly upon the importance of the loyalty of each alumnus to his Alma Mater, and that the success of a college always depends upon the success of its graduates.

Dr. F. J. Bauer, of Mogadore, Ohio, answered to the call for the class of '80.

The class of '86 was represented by Dr. H. W. Powers, of North Amherst.

Dr. Fannie Goodsell represented the class of '87.

The class of '88 was answered for by Dr. W. J. Wood, of Medina, Ohio.

Class of '91 was represented by Dr. Lower, of Cleveland.

Class of '92, by Dr. Amanda H. Miller, whose paper will be published later.

Class of '99 was represented by Dr. G. Y. Davis.

The report of the nominating committee was then read, as follows: President, N. S. Everhard, Wadsworth, O.; First Vice-President, G. B. Woods, Washington, Pa.; Second Vice-President, H. W. Powers, North Amherst, O.; Third Vice-President, H. C. Crumrine, Cleveland, Ohio; Secretary, H. B. Ormsby, Cleveland, Ohio; Treasurer, I. N. Hintzleman, Cleveland, Ohio.

The next meeting will be held in the new college building on next commencement day, when a still larger attendance is expected.

H. B. ORMSBY, M. D., Sec.

## COMMENCEMENT OF THE CLEVELAND COLLEGE OF PHYSICIANS AND SURGEONS.

One of the most successful commencement celebrations in the history of the college was held in the First Methodist church, Cleveland, on the evening of Wednesday, May 2d, 1900, when twenty-four graduates made their initial bow to a very large audience of their friends and the friends of the college.

The program of the exercises comprised addresses by the dean, Dr. C. B. Parker, and Rev. Louis Albert Banks, pastor of the First Methodist church, the conferring of the degree by Rev. Dr. A. J. Lyon, and excellent orchestral music.

Dr. Parker's address to the class was interesting and instructive. He spoke of public interest in medical education and especially in the medical and surgical discoveries.

Rev. Dr. Banks delivered a practical and inspiring address with good and useful advice to the young doctors. He said "There are three epochs in the life of a physician—first when he decides to become a doctor; second, on the day when he receives his diploma, and third, when he makes his first success, be it large or small." He spoke at length on specialties and that specialism in medicine, as in everything else, tends to make one narrow, and urged the young doctors to broaden their minds, not only on medical topics, but on literature, history, art and science. The speaker concluded his reference to specialties, however, by saying, "that the keen competition at the present time makes it difficult to devote much time to other topics."

The presentation of diplomas was made by Rev. Dr. A. J. Lyon, acting President of the University.

The graduates were recipients of many beautiful bouquets of flowers.



At the conclusion of the exercises the faculty tendered a banquet to the graduates, alumni and friends of the college at the Forrest Ctiy House, where one hundred and sixty persons enjoyed the excellent menu. The table decorations were beautifully and artistically arranged, and after the supper the guests were delightfully entertained by toasts.

The University ("Mother of arts and eloquence"—Milton), was responded to by Rev. A. J. Lyon, D. D.; The Alumni ("Knowledge comes, but wisdom lingers."—Tennyson), Wm. C. Bunce, M. D.; The Legal Profession ("The gladsome light of jurisprudence."—Sir Edward Coke), Judge F. J. Wing; The Faculty ("He teaches best who feels the hearts of all men in his breast, and knows their strength or weakness through his own."—Bayard Taylor), S. W. Kelley, M. D.; The Class ("The spirit of youth, that means to be of note begins betimes."—Antony and Cleopatra), H. C. Crumrine, M. D.; The Friends of the College ("Sweeter none than voice of faithful friend."—Robert Pollok), Wm. F. Walworth; The Ladies ("So womanly, so benigne, and so meke."—Chaucer), W. A. Knowlton, M. D.

Dr. J. B. McGee, as toastmaster, displayed his usual store of good humor and eloquence. The toasts were followed by Dr. G. H. Fitzgerald's poem on "The Old College Building."

Following is a list of the graduates: Archibald Clair Adams, Ph. G.; Rollin R. Adams, David Thomas Bailey, Harry Bookwalter, Ph. G.; Thomas Arthur Costello, Henry Charles Crumrine, Henry Edelstein, Ph. C.; Nathan Edward Friedman, Joseph Gottlob, Benjamin Franklin Hambleton, B. S.; Wencelaus Frank Hribal, Ph. C.; Frederick William Linn, Orville Thomas Manley, B. L.; Van Newhall Marsh, M. D.; William Arthur McConkey, B. S.; Myron Metzenbaum, B. S.; Isidor J. Propper, Charles Edward Richards, Louise Santoro, Thurman Cecil Siffert, Lloyd Daniel Trowbridge, A. M.; Asa Fleming Voak, Charles Edward Ward, Albert Merrill Webster.

GRACE D. OUTLAND.

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#### THE SIXTH ANNUAL MEETING OF OHIO STATE PEDIATRIC SOCIETY.

The sixth annual meeting of the Ohio State Pediatric Society was held at the Y. M. C. A. Building, Columbus, O., May 8th and 9th, 1900. Dr. T. Clarke Miller presided, and in the absence of the Secretary, Dr. D. S. Hanson, Dr. S. W. Kelley acted as Secre-

tary *pro tem*. Dr. John W. Murphy, of Cincinnati read a paper on "Acute Mastoiditis," and exhibited numerous specimens, anatomical and pathological. "Milk Contamination and Methods of Prevention," by Dr. D. S. Hanson, of Cleveland, was read by Dr. D. L. Moore, of Columbus. "Intubation and Antitoxin" was the subject of a paper by Dr. H. H. Jacobs, of Akron, followed by one on "Treatment of Hernia in Children," by Dr. F. F. Lawrence, of Columbus.

The members of the society then repaired to the Great Southern Hotel, where the local committee tendered a complimentary dinner, which proved a very enjoyable affair.

In the evening session Dr. A. W. Steinfeld was elected to membership, and a committee on nominations, consisting of Drs. Coleman, Kelley and Moore, was appointed.

The President then delivered his address, entitled "The Submergence of Individual Judgment," which was much appreciated, and referred to a committee. The committee recommended a vote of thanks and the publication of the address. It will appear in the GAZETTE. "Report of a Case of Chorea Following the Removal of Adenoids and Tonsils," by Dr. E. W. Montenyohl, of Akron, was read by Dr. Jacobs.

At the Wednesday morning session Drs. J. W. Murphy and H. H. Jacobs were elected to membership.

Dr. J. B. McGee's article on "Thyroid Extract in a Case of Cretinism," illustrated with fine photographs, was read by Dr. Kelley, and a "Statistical Study of Defective Vision of Cleveland School Children," by Dr. L. K. Baker, of Cleveland, was also read by the Secretary in the absence of the writer. "Convulsions in Children" was the title of a paper by Dr. Wm. A. Dickey, of Toledo, and the program closed with the reading of "Anodynies in Children," by Dr. R. R. Pettit, of Dayton.

The question of time and place of the next meeting was left in the hands of the council to decide.

The officers elected for the ensuing year are: President, Dr. J. M. Dunham; First Vice-President, Dr. J. W. Murphy; Second Vice-President, Dr. H. H. Jacobs; Secretary and Treasurer, Dr. D. S. Hanson; members of the Council, Drs. F. W. Blake, O. T. Maynard, J. M. Dunham, W. A. Knowlton and J. B. McGee.

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Our attention has been called to the following telegram which has been sent out from a leading chemical house in New York, to other chemical house in the States: "We learn from

good authority that the foreign chemical houses will attempt to elect their allies as chairman and members Section on Materia Medica of the American Medical Association at the Atlantic City meeting. Many good men are with them, without realizing the underhanded scheme, which is to discard American products and endorse only foreign. We should expose the plot with all possible haste, by communicating with every Medical Journal in which we and other American houses carry advertisements, and ask their co-operation." Comment is unnecessary. We believe the American physicians, if cognizant of such action, will promptly frustrate any such attempt on the part of the foreign chemical house.

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### Periscope.

*Influence of Bile, of Acid, and of Alkalis on the Proteolytic Action of Pancreatic Juice.* By Benj. K. Rachford (*J. Physiol.*, 1899, 25, 165). Experiments were made with pancreatic juice (not extracts, as Chittenden used) and bile of the rabbit. These confirm the conclusion arrived at previously, although denied by Chittenden, that bile much favors the proteolytic action of the juice. Bile, however, retards the albuminous fermentations carried on by organized ferments. When pancreatic juice is added to fibrin half saturated with hydrochloric acid, it does as much work as on neutral fibrin. If fibrin is nine-tenths saturated with the acid, proteolysis is retarded; this retardation also occurs in the presence of bile. Free hydrochloric acid greatly inhibits, but does not destroy, the proteolytic action, whilst sodium carbonate is favorable, especially in dilute solutions of pancreatic juice. The general conclusion is drawn that the conditions in the entire small intestine are favorable to the proteolytic activity of pancreatic juice.

*The Influence of Removal of Water on Metabolism and Circulation.* By Walther Straub (*Zeit. Biol.*, 1899, 38, 537). The effect of sodium chlorid in producing a slight increase of proteid catabolism is attributed to its diuretic action, water being removed from the tissues. The present experiments on dogs were designed to test this theory by a removal of water from the food; this was found to increase proteid catabolism, but to have no influence on fat. The blood pressure is not altered, but the quantity of water lost by skin and lungs is slightly lessened.



*Influence of the Kind and Amount of Nutriment on Metabolism.* By Edward Pflueger (*Pflueger's Archiv*, 1899, 77, 425). The object of the paper is to show that proteid is the great source of energy; it increases metabolism, and raises resistance and power of the animal; it does so by increasing the substance of the living cells, sometimes even doubling their weight. Fat and carbohydrate have no such power. Fat never arises from proteid in the animal body. Man cannot take all his nutriment in the form of proteid simply because of the limitation which exists in his digestive power.

*Metabolism of Nucleines.* By T. H. Milroy and J. Malcolm (*J. Physiol.*, 1899, 25, 105). In a case of lymphatic leucocythæmia, the phosphoric oxide excreted was diminished both absolutely and relatively to the nitrogen excreted, whilst the uric acid and alloxuric bases was hardly affected. In a case of medullary leucocythæmia where the number of leucocytes was falling, the excretion of phosphoric oxide underwent no diminution, whilst the alloxuric excretion varied greatly. An investigation of the characters of the granules in the colorless corpuscles of marrow and blood was carried out by micro-chemical means. Nucleic acid and its principal decomposition products (thymic acid, adenin, guanin, cystosin) alter the staining affinities of oxyphil granules, making them finally basophil. The granules are nucleoproteid, and the action of the nucleinic acid is to cause the cell to give up the albumin and leave a more acid residue, nuclein. The subsequent discharge of the residue leads to an increase of excreted phosphoric anhydrid; this probably occurs in the body when nucleic acid is liberated. The granules readily undergo changes, and a study of them is important, for these affect the general metabolism.

*The Proteid-sparing Action of Alcohol.* By Rudolph Rosemann (*Pflueger's Archiv*, 1899, 77, 405). Miura, Schmidt and Schoenseiffen found that alcohol has no proteid-sparing action. The paper confirms this, and criticises Neumann's recent work, which appeared to show the contrary.

*Origin of Fat from Proteid.* By Edward Pflueger (*Pflueger's Archiv*, 1899, 77, 521). Polemical. Pflueger is well known to be an unbeliever in Voit's doctrine that fat can originate from proteid in the body; his remarks here are mainly directed against Max Cremer, the latest exponent of Voit's theory.

*Phosphorus in Muscle.* By J. J. R. Macleod (*Zeit. Physiol. Chem.*, 1899, 28, 535). By muscular work, the originally united

phosphorus in aqueous extracts of muscle is greatly diminished, but the inorganic phosphates are increased. The lessening is due partly to a diminution of phosphorus in nucleon, but especially to that in organic phosphorus compounds other than nucleon.

*Koppe's Theory of the Formation of Hydrochloric Acid in the Stomach.* By John A. Wesener (*Pflueger's Archiv*, 1899, 77, 483). Koppe's theory of the formation of hydrochloric acid in the stomach is that ionisation of the sodium chlorid in the stomach, and of the acid carbonates and phosphates in the blood, occurs, and that an exchange of the hydrogenions in the blood, and sodium ions of the stomach then takes place. The following experiments show this cannot be the case, but that the acid is the result of cell activity. If the stomach is well washed out, and a 0.7 per cent. solution of sodium chlorid introduced there is no formation of free acid, but if the stomach be irritated by the rotation of a revolving sound in its interior, whether sodium chlorid solution be there or not, free hydrochloric acid appears, reaching a percentage of 0.1 in a few minutes.

*The Lactose of the Pancreas.* By Ernst Weinland (*Zeit. Biol.*, 1899, 38, 607). In both young and adult dogs the pancreas in virtue of a lactose converts lactose into dextrose and galactose, this power being increased by a milk diet. By prolonged boiling with citric acid acid lactose is similarly acted upon. There is no evidence of any intermediate substances between lactose and its hydrolytic products.

SPENZER.

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## New Books.

**INJURIES TO THE EYE IN THEIR MEDICO-LEGAL ASPECT.** By S. Baudry, M. D., Professor in the Faculty of Medicine, University of Lille, France, etc. Translated from the original by Alfred James Ostheimer, Jr., M. D., of Philadelphia, Pa. Revised and edited by Charles A. Oliver, A.M., M.D. Attending Surgeon to the Wills Eye Hospital; Ophthalmic Surgeon to the Philadelphia Hospital; Member of the American and France Ophthalmological Societies, etc. With an adaptation of the Medico-Legal Chapter to the Courts of the United States of America, by Charles Sinkler, Esq., Member of the Philadelphia Bar. 5½x7½ inches. Pages, x-161. Extra cloth, \$1.00, net. The F. A. Davis Co., publishers, 1914-16 Cherry St., Philadelphia, Pa.

This book presents to the reader mainly the prognostic side of injuries to the eye. It brings together in a very concise and clear manner much information that is frequently required and for

which we would require to make long search in our reference works.

The chapter on medico-legal expert testimony is timely and will certainly be appreciated by the novice.

Altogether the book is very appropriate and should find a place in the library not only of the physician, but also of the lawyer.

LAUDER.

**A MANUAL OF THE PRACTICE OF MEDICINE PREPARED ESPECIALLY FOR STUDENTS.** By A. A. Stevens, A.M., M.D. Professor of Pathology in the Women's Medical College of Pennsylvania, etc. Fifth edition. Revised and enlarged. Illustrated. Octavo. Pages 519. \$2.00 net. Philadelphia. W. B. Saunders. 1898.

This edition has been thoroughly revised and contains important modifications and additions. A chapter on diseases of the pancreas, an introductory chapter on diseases of the blood and of the ductless glands, the articles on myxedema and syringo-myelia have been entirely rewritten and there have been introduced new articles treating of acute cholecystitis, tuberculosis of the kidney, gasteroptosis, enteroptosis, and chronic lepto-meningitis. The work is a handy reference book, and well worth its price.

TUCKERMAN.

**ESSENTIALS OF ANATOMY. INCLUDING ANATOMY OF THE VISCERA. ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS. PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE.** By Charles B. Nancrede, M. D. Professor of Surgery and Clinical Surgery in the University of Michigan, etc. Sixth edition. Thoroughly revised. By. Fred. J. Brockway, M.D., Assistant Demonstrator of Anatomy, Columbia University, New York, Octavo. Pages 419. \$1.00 net. Philadelphia. W. B. Saunders. 1899.

This work is No. 3 of Saunder's Question Compendis. The cuts are reduced from those of Gray's Anatomy. It fulfills its purpose as a question compend for students admirably.

TUCKERMAN.

**A TEXT BOOK OF DISEASES OF WOMEN.** By Chas. B. Penrose, M.D., Ph.D., Professor of Gynecology University of Pennsylvania. Surgeon to the Gynecean Hospital, Philadelphia. Publisher, W. B. Saunders, Philadelphia.

This is the third edition of this work that has been placed before the profession in three years—a fact which shows the popularity of the work. The author has revised and brought up to date this last edition, adding four chapters on disorders of men-



struation and sterility. The work is particularly rich in its plain and clear description of operative procedures, and contains one of the best descriptions of repair of lacerated perineum ever written. The work is peculiar in that it omits the pathology and anatomy which is found in the general text books on these subjects, in this way saving much space which is profitably devoted to other subjects. No space is taken up in the discussion of those topics and points not yet definitely settled, but this does not mean that the author has not strong and advanced ideas on gynecological subjects, as is shown in the following: He recommends the repair of lacerated cervix in every woman approaching the meno-pause on account of the frequent association of cancer with that condition. Operation is advised in all fibroid cases, as other treatment is rarely successful; pus in the pelvis in the great majority of cases ought to be attacked from above and not per vaginam; vaginal hysterectomy is recommended only where uterus or uterus and tumor is sufficiently small to pass through the vagina. Altogether this may rightly be said to be one of the best works on gynecology now published, and is particularly good in operative gynecology.

CLARK.

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THE INTERNATIONAL TEXT-BOOK OF SURGERY, BY AMERICAN AND BRITISH AUTHORS. Edited by J. Collins Warren, M.D., LL.D. Professor of Surgery in Harvard Medical School; Surgeon to the Massachusetts General Hospital, and A. Pearce Gould, M. S., F. R. C. S. Surgeon to Middlesex Hospital; Lecturer on Practical Surgery and Teacher of Operative Surgery, Middlesex Hospital Medical School; Member of the Court of Examiners of the Royal College of Surgeons, England. In two volumes. W. B. Saunders, 925 Walnut St., Philadelphia, 1900. Volume I 458 illustrations in the text, and 9 full-page plates in colors. Volume II 471 illustrations in the text, and 8 full-page plates in colors.

The first volume is devoted to general and operative surgery, and the second to a masterful treatment of regional surgery. The contributors are: Vol. I., Drs. C. H. Golding Bird, Edward H. Bradford, J. G. A. Burns, Herbert L. Burrell, Richard C. Cabot, I. N. Cameron, W. Watson Cheyne, J. Chalmers Da Costa, Harold C. Ernst, George Ryerson Fowler, George W. Gay, John B. Hamilton, George H. Makins, Charles McBurney, George H. Monks, Rushton Parker, Lewis C. Vilcher, Franz Pfaff, Maurice H. Richardson, Guy Bellingham Smith, Walter George Spencer, J. Bland Sutton, L. McLane Tiffany, Weller Van Hook, James P. Warbasse, J. Collins Warren, DeForest Willard; Vol. II., Robert W. Abbe, William T. Bull, James Cantlie, William Bruce

Clarke, William B. Coley, E. Treacher Collins, H. Holbrook Curtis, N. P. Dandridge, John B. Deaver, John W. Elliott, Christian Fenger, W. H. Forwood, A. Pearce Gould, J. Orne Green, M. L. Harris, Fernand Henrotin, Rudolph Matas, Charles McBurney, Andrew J. McCosh, Lewis S. McMurtry, J. Ewing Mears, John Murray, Robert W. Parker, George A. Peters, James J. Putnam, A. W. Mayo Robson, William L. Rodman, Charles A. Siegfried, H. Tuholske, Weller Van Hook, J. Collins Warren.

The work is beautifully and fully illustrated, and is clear, thorough, and up-to-date in every respect.

Surgery in all of its branches, is most capably handled, and the book is a most valuable addition to the surgical literature of the day.

G. S. S.

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## **Society Proceedings.**

May L. Bassett, Medical Reporter.

### **CUYAHOGA COUNTY MEDICAL SOCIETY, MAY 3, 1900.**

The Cuyahoga County Medical Society held its regular meeting at the Cleveland Medical Library Building on Thursday, May 3, at 8:15 p. m., with the President, Dr. C. J. Aldrich, in the chair. The minutes of the last meeting were read and approved. The name of Dr. Hal K. Bishop was read for active membership, and after motion to that effect, was placed upon the rolls of the society. The committees appointed to report at this meeting were not all present, and but a partial report was received, the full report being postponed to another meeting.

A letter was read from Dr. Henry C. Eyman, tendering his resignation as a member of the society on account of removal, which resignation was accepted.

Under the heading of miscellaneous business the question of program of the society was brought forward. The President said:

We have experienced some little difficulty as to the amount of work which the members of this society could be induced to do, and it has suggested itself to me that this could be made a very active society by following out a little different plan as to our programs. First, it seems to me that our meetings would be of far more interest if we would take up some one topic, as for instance, tuberculosis, and have a number of evenings to devote to

the different branches of this topic, securing men to read papers on tuberculosis in their own specialty, as tuberculosis of the lungs, tuberculosis of the brain, tuberculosis of the stomach, tuberculosis of the kidneys, all specially prepared papers, and each topic occupying an evening, the discussion being held at the last after the reading of all the papers of the evening upon the one branch of the topic chosen. Second, let us have these papers all published at the expense of the writers—and I think that almost any writer would be willing to bear this expense—let us have these published in the CLEVELAND MEDICAL GAZETTE, as they will print them for us at the mere cost of printing, and furnish reprints at the same rates. Then when we have completed the papers upon all the branches of a topic, let us have them bound at the expense of the society and furnished to the medical libraries throughout the country. The GAZETTE agrees to publish them at the cost of paper and presswork.

*Dr. Large:* It seems to me that the suggestion is a good one, and I would like to mention that aside from the question of program, the place of meeting might be a great drawback to the success of this society. This is not a central place, and a great many men from the west and south sides might come if it was more centrally located. The Cleveland Medical Society tried this as a place of meeting, and during the whole time of meeting here did not have a very large attendance, but the very first night at the Arcade they had a large meeting. It seems to me that Dr. Aldrich's suggestion is a good one, and that it would give the general practitioner a good chance as well as the specialist. When these papers are published in book form they would make a very convenient and serviceable book.

*Dr. Campbell:* I am sure that the doctor knows I agree with him about the study of one topic in all its branches, as it was one of my hobbies when I was President, only I was so unfortunate as to start that kind of program too late in my term of office to carry it through, instead of beginning at the start, as the doctor has done. I think much more can be gained from having one topic and studying it thoroughly than from taking up so many subjects. I had not thought of the scheme of having them printed, however.

*Dr. Aldrich:* I think the plan of having them printed would result favorably because the men taking part will put their best work forward.



*Dr. Campbell:* It is certainly true that we have the men to do this work. It is hard to get a full attendance at our meetings in this society, but we have the ability among our members to do better work than we have been doing.

*Dr. Stuart:* The matter of program has been a subject that has worried me continually, and I have thought this year that we might make some advance along this line. I have wondered if it would not be a good plan, now that our treasury has a surplus in it at the beginning of the year, to offer prizes for the best papers. It seems to me that the expenditure of our money in this way would be far better, and have more permanent results in building up the Society than for such things as the Cleveland Medical Society has spent its money. They spent more money this last year than their income, and the records showed that the amount was spent for "smokers" and like affairs. It has occurred to me that if we would establish a few small prizes for the best papers of the year or best upon the given topics, it would be of permanent value to us.

*Dr. Aldrich:* I have learned by a little correspondence that if we follow out this plan carefully, that at least three of the large medical weeklies will publish our proceedings, and one of them has already promised to pay part of the expenses of this, and I am in correspondence with two others that I think will grant the same concessions, and if they do, I think we can follow up Dr. Stuart's suggestion. None of the writers of the papers need be known except by number, so that there may be perfect fairness in the awarding of the prizes.

In regard to a change of place of meeting, if we have a good attendance I think we would be warranted in taking up the question. I think, with Dr. Large, that this place has not proved a good one for meeting, for the Cleveland Medical Society did not have so large an attendance while here. I think perhaps we had best not take up this plan with regard to the topics this spring, as we have but two more meetings this year, and as any one of these topics would take at least four meetings, it might be better to wait till fall. I think it would be a good idea also to have as little business as possible transacted at these meetings,—absolutely no business would be better yet, but just take up the topic, having all the papers read and the discussion following.

The regular program of the evening was called, first in order being the reading of Dr. W. E. Shackleton's paper upon "Mas-toiditis."

*Discussion: Dr. Foote:* The first case cited by the writer I had the pleasure of seeing at the time the complication occurred. The question of operation is, to my mind, a serious one in acute febrile cases. I think it should almost always be postponed if possible in such cases on account of the dangers resulting from the use of anesthetics and the danger of shock. I think if the anesthetic had been administered during that week, even though there was every surgical indication for which operation for mastoiditis should be performed, that the result would probably have been death from shock, and the report shows that the conservative course was the better.

Though there is some danger of septic meningitis occurring if the operation be postponed, still the risks of the operation would more than counterbalance the dangers from this complication, which is very rare in typhoid fever.

*Dr. Aldrich:* The question that Dr. Foote raises is a very important one. We should be very careful about administering anesthetics in acute cases. Eastern physicians who have performed these operations report the use of cocain as a local anesthetic. Dr. Cushing recently reports a case on which he operated for perforating ulcers in typhoid, and he used cocain. This goes to show that physicians who are authorities consider the administration of anesthetics in these cases as very dangerous. I want to ask Dr. Shackleton if he noticed in these cases a symptom that I have called attention to, and that I had mentioned to him, and that was on the side of the affected mastoid has a soft, silky feeling to the touch, a sort of velvety feeling occurring in chronic cases. This is a symptom which I believe is not recorded by any of the authorities, is one which I have noted in several cases, and I wish to know if the doctor noticed it in these cases.

*Dr. Shackleton:* No, the symptom was not noticed in either case; one was seen before I learned of its occurrence, the other was an acute case.

*Dr. Aldrich:* I have asked all my friends to note this symptom; it may have been casual in the cases in which I observed it.

*Dr. Shackleton:* Another thing that might be said about this is that while the outer wall is thickened and not easily perforated, the necrosed inner walls are non-resistant, and slight pressure will force the pus through.

*Dr. Large:* Was there any delirium?

*Dr. Shackleton:* Yes, about three or four hours before the operation the patient became delirious. I think the sudden occur-

rence of pain marked the time of rupture into the meningeal cavity.

*Dr. Foote:* I would like to ask the doctor if in septic meningitis he would advise operation, and whether such operations are not universally fatal?

*Dr. Shackleton:* They are usually fatal, but they offer the only chance to the patient, and I advise operation for another reason and that is because the diagnosis may not be correct. You know we get many of the same symptoms in extradural abscess.

*Dr. Aldrich:* This raises another question upon this point. You know that pain is often experienced in these chronic cases, and if the attendant has been a little careless and allowed the patient to have morphine too freely they not infrequently form the habit. I recall a case that was under the care of an aural surgeon in which the patient, who had become better, was suddenly taken with a sudden rise of temperature and became delirious. The surgeon became very much alarmed, as there had been such a happy termination of the case, at first. I was called in consultation and could not find anything indicating any difficulty arising from the mastoid. I suspected that the patient might be a morphine-eater, and inquiry revealed this fact. We prescribed morphine and the temperature dropped to normal in a short time, proving that the cutting off of morphine after operation had been the cause of the sudden rise of temperature and unfavorable symptoms. This is an important point for the aural surgeon to remember.

*Dr. Shackleton:* In closing the discussion I have nothing further to say, except to call attention to the one point I had wished to make most prominent, and for which I reported these cases, and that is that we do not always have swelling and tenderness over the mastoid process in mastoiditis, and particularly is this true in the cases resulting from chronic purulent otitis media.

*Dr. Campbell:* I think the doctor is right in saying that this is the second case reported, and this is strange, for typhoid is apt to leave ulcerative processes like this. I have even seen an eye suppurate and come out, and it is a common thing to have all kinds of suppurative processes as a sequel to typhoid fever.

Dr. S. H. Large then exhibited an electric pressure sound for use in ankylosis of the ossicles and direct massage of the membrana tympani. He read a short paper upon its use, and demonstrated the workings of the sound to the society. He stated that he had seen Dr. Lester, of New York, use it in forty cases of



catarrh of the middle ear. Dr. Large's paper will appear in a subsequent issue of the *GAZETTE*.

*Discussion: Dr. Aldrich:* How long do you make application of it?

*Dr. Large:* From five to ten seconds. There is no pain when it is used,—just a sensation like that of a fly buzzing in the ear.

*Dr. Foote:* Did you use politzerization also in all these cases?

*Dr. Large:* Yes, almost all of these cases had had politzerization before coming to me.

*Dr. Shackleton:* You do not know then what the result of the use of the electric pressure sound would have been used alone?

*Dr. Large:* No, I do not know what the effect of the sound would be without politzerization.

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## TRANSACTIONS OF THE FIFTY-FIFTH ANNUAL MEETING OF THE OHIO STATE MEDICAL SOCIETY.

Abstract from Stenographic Report.

Columbus, May 9th, 1900.

The fifty-fifth annual session of the Ohio State Medical Society was called to order by the President, Dr. Rufus B. Hall, at 1:45 p. m., May 9th, 1900, in the Y. M. C. A. auditorium, Columbus. The address of welcome was made by Hon. Joseph H. Outhwaite. Response was made by the President.

The report of the Committee of Arrangements was made by Dr. Clovis M. Taylor. The committee reported that cars would leave corner of Broad and High Streets at 7 p. m. for Ohio Institution for Feeble Minded Youths, where Dr. G. A. Doren would give a reception to members and visiting ladies. The committee also announced that the annual banquet would be given at the Great Southern Hotel Thursday evening at 8 p. m. Communications from Association of Medical Libraries, asking for a vote of 50 copies of the transactions of the society. Communications referred to Executive Committee. Communication from Secretary of Rush Monument Fund read and referred to Executive Committee. Moved and carried that the Secretary be authorized to employ a stenographer to report the transactions of the meeting. The President then appointed as the Committee on Nominations Drs. J. C. Oliver, Cincinnati; W. C. Chapman, Toledo; J. M.

Barnhill, Columbus; W. W. Pennell, Fredericktown, and P. Max Foshay, Cleveland.

The regular program was then taken up and the following papers presented:

"A Plea for the Earlier Use of the Obstetrical Forceps" was the title of a paper by Dr. John M. Fassig, of Zanesville. The writer considers the forceps a subservative and preservative instrument. By early application we have a stronger mother to operate upon. Formerly mothers were allowed to suffer four to six days and then the child was still born. Educate the mothers to the use of forceps.

*Discussion. Dr. Chapman:* Think the forceps are used too soon as often as too late. Think the perineum is too often ruptured by the use of forceps. Do not be too aggressive. Think they are all right in their place.

*Dr. Haldeman.* I am in favor of the early application of the forceps. Make it a rule after complete dilatation of the cervix, if there is not some progress within an hour apply the forceps. Think they prevent rupture of the perineum.

*Dr. Baldwin:* From a practical standpoint the most of the lacerations I have met with came from the use of forceps. Think there should be a law prohibiting the application of forceps in primipara for twenty-four hours from beginning of labor.

*Dr. Miller:* Think the forceps a great instrument, but do not think we need any advice to use them early. They are dangerous in the hands of unskilled physicians.

A paper, "Puerperal Eclampsia; Its Cause and Treatment," by John E. Sylvester, of Wellston, Ohio. Causes: Renal and hepatic insufficiency with an excess of the products of foetal metabolism, uraemia from the retention of urates caused by overwork on the kidneys. The kidneys have to eliminate not only the effete matter of the mother, but that of the child also. Hepatic insufficiency is substantiated by the fatty degeneration in the liver in these cases. Treatment: Stop the convulsions by sedatives. If in a plethoric patient, bleed. Bleeding may be substituted by constricting the vessels of the arms and legs. Chloral per rectum, 20 or 30 grains. Hypodermic injection of morphia in large doses. Use veratrum in large doses, keeping the pulse below 60. Chloroform. If the os is patulous, deliver; if rigid, wait.

*Discussion. Dr. Kinsman:* Excepting aura irritation, the convulsions are caused by renal insufficiency. I am in favor of bleeding. Morphine in irritable convulsions.

*Dr. Halderman:* Would not have the nerve to give a patient 1 gr. of morphine, or even  $\frac{1}{2}$  gr.; think active catharsis is advisable.

*Dr. Means:* I rely on morphine. Early catharsis is advisable and the early manual delivery of the child.

"Subphrenic Abscess Following Appendicitis," by Dr. J. F. Baldwin, Columbus. Reported two cases. This is not a new trouble, but has not been very frequently reported. The abscess may be intra or extra peritoneal. They usually occur on the right side. Symptoms: Pain in the right shoulder, hiccough, fever, emaciation and headache. The abscess may contain gas or pus. The mortality is very high, about 5 per cent. recover.

*Discussion: Dr. Freiberg:* This trouble is more frequent than is believed. The majority contain gas, produced by suppurating lines in the abdominal cavity extending from the original seat of infection. Those containing gas are the more easily recognized.

*Dr. Means:* Have seen one case and could not discover the source. The source is oftentimes due to infection through the lymphatics. Often the glands are enlarged and suppurating.

A paper, "Inguinal Colostomy," was read by Dr. John C. Oliver, Cincinnati. Cases requiring operations are mostly neoplasms or malignant growth in the rectum and contractions from venereal ulcerations manifested by severe pain with small movements of the bowels, lack of sleep, tenesmus and deterioration of the general health. Ordinarily in these cases colostomy only protracts a miserable life with no hope of relief.

A paper, "The Value of a Healthy Throat," was read by Dr. W. W. Pennell, Fredericktown. No child can be too young to have enlarged tonsils. Children with bad throats are rendered more susceptible to other disease. In enlargement of tonsils the cheesy matter in the crypts are a menace to health and the constant swallowing of catarrhal exudate cause gastric disturbance. An inflammatory condition predisposes to adenoids and affects hearing through extension by way of the eustachian tubes. Early removal should be practiced.

A paper, "Tonsillar Obstruction in the Fauces and Pharynx," was read by A. W. Francis, Ripley. Tonsillar hypertrophy is a large field of study. The most common is the adenoid form, in the young they are soft, in adults hard, and should be located by the finger of the examiner. The most constant symptoms are headache, dullness of intellect, mouth breathing and predisposition to



take cold. They usually affects the hearing. They should be removed.

A paper, "The Infectiousness of Follicular Tonsillitis," was read by Dr. C. A. Hough, Lebanon. The author reported 520 cases in one locality where it became epidemic. The constitutional symptoms were constant and appeared six days after exposure. There was in no case any membrane, so it could not be a mild form of diphtheria. The epidemic was infectious and contagious. While follicular tonsillitis is not always infectious it may become so at times.

Drs. Pennell, Francis and Hough's papers were discussed jointly by Dr. Thompson. There is nothing in the domain of surgery that gives patients so much relief as the removal of hypertrophied tonsils and adenoids. It has been found endocarditis has followed tonsillitis, and it also predisposes to diphtheria. The dangers of removal are slight. Relief does not come immediately, but in about six weeks.

A paper, "The Diagnosis and Treatment of Metatarsalgia," by Dr. A. H. Freiberg, Cincinnati. Metatarsalgia is a neuralgic pain usually at junction of fourth and fifth metatarsal bones, believed by some to be due to depression of transverse cut of foot, although it occurs in seemingly normal feet. The disease is divided into acute, sub-acute and chronic cases. The constant symptom is pain with tenderness at point of pain. The conclusions are that metatarsalgia is a symptom of severe pathological condition of foot, and sometimes possibly a constitutional disease. It is possible to completely relieve many cases, without operative interference, by establishing an exact diagnosis of the condition and directing treatment accordingly.

*Discussion: Dr. Oliver:* It is remarkable how frequently flat foot is found among men who do hard labor, but I have not generally found metatarsalgia associated with it.

THURSDAY MORNING, MAY 10, 1900.

Meeting called to order at 9:20 a. m.

After reading the Secretary's report of Wednesday's work, the program was continued.

A paper, "The Treatment of Consumption at Home," by Joseph Eichberg, M. D., Cincinnati, was read. This disease cannot be placed in the category of diseases in which a specific has been found, yet it is nearing that point, and honest, patient en-

deavor can help the patient in his affliction. The more recent discovery of anti-toxine has led to the hope of a specific, which has probably led us astray. The accumulating experience of the last few years shows that altitude has little to do. Give the patients twenty-four hours a day in open air. Open bed rooms, winter and summer, day and night. Fresh air in abundance comes first. Good food second. Forced feeding regardless of gastric symptoms. Allow the patients anything to eat they may want, except coffee, tea and alcohol, which should be limited. Third, good rest. Rest absolutely, continuously, and cheerfully, thus you lessen the waste process.

*Discussion: Dr. Sawyer:* Think well of the home treatment. Sending away patients does harm. We must feed according to the chemistry of the stomach. Patients should have thirty minutes' rest immediately after meals. Sugar is of great value.

*Dr. Millikin:* The benefits of climate is not well understood. The particular climate does not matter so the air is aseptic. My experience has been that pregnancy improves consumptives.

A paper, "Sudden Deaths," by Louis Schwab, Cincinnati. In sudden deaths a search should be made for the cause. Records should be made and preserved by physicians. Sudden death applies to deaths which are not or only shortly preceded by morbid phenomena. The popular belief that the heart is at fault in the majority of sudden deaths is being discredited. Not a little less than one-half are due to disease of the kidneys, as shown by autopsies.

A paper, "Operations Upon the Biliary Passages," by Dudley P. Allen, Cleveland. Early operations are essential, and are fraught with less danger. The longer the delay the greater the adhesions, and the more difficult the operation with less chance for recovery. Malignant disease need not interfere. Often find obstruction of biliary passage where the common symptoms are absent, hence all cases of distress in epigastric region should be studied. Dangers of secondary hæmorrhage in old cases is great. Do not believe in the indiscriminate and needless operations, but advise operation as soon as a sure diagnosis can be made.

A paper, "The Medical Treatment of Gallstones," by E. S. Stevens, Lebanon. The treatment of this disease by drugs is limited. There is no medicine that will dissolve gall stones. The practice of trying to empty the gall bladder by massage is dangerous. Operation is the only method for a cure. Treatment may relieve the symptoms between paroxysms. Opiates make the patient worse. Local applications are not much good, but are prac-

tically harmless. Relieve flatulence and constipation by laxatives. Salines, castor oil and olive oil. Their effect upon the engorged hepatic circulation is to relieve the congestion.

A paper, "Alcohol; Its Place," was presented by Dr. R. T. Trimble, New Vienna. Alcohol is not a food in any sense of the term. It belongs to poisonous drugs and should be classed as such. It should always be remembered that it supplies nothing toward tissue waste, but on the contrary it causes parendigmatous and muscular degeneration. Its place in medicine is a small one. It is a stimulant to the heart, and is of some value after continued sickness. It is indicated in pneumonia and typhoid fever and tuberculosis. It is contra-indicated in meningeal and brain diseases.

Ajourned.

Call to order, 1:30 p. m.

Report of Secretary. Sixty-eight members were elected to the society last year, 44 were dropped, 1 resigned, and 10 died. Membership, 885. The Secretary recommended that members who had forfeited their membership be reinstated by paying their back dues. Report referred to Executive Committee.

Treasurer's report was then read. Report shows a balance in treasury of \$136.67. Report referred to Executive Committee.

Committee on Admission made a partial report by recommending 62 names for admission. The names were adopted.

Finance Committee reported the books in good condition. The chairman of the committee moved that the Treasurer's books be sent to chairman of Finance Committee one month before annual meeting of the society to be audited. No second. Committee's report referred to Executive Committee.

Committee on Publication reported that sealed bids had been received for the publication of the transactions, and as J. B. Savage was the lowest bidder the contract was awarded to him at \$560.00. Dr. P. Max Foshay was selected as editor at \$100.00. Report referred to Executive Committee.

Committee on Growth and Prosperity. Dr. Humiston stated they did not have a meeting last year, but would do more effective work the coming year. Suggested that the place of meeting be changed around more generally from year to year.

Committee on Medical Legislation made a lengthy report, reviewing the work of the committee and its success in bringing about the passage of a splendid law, by which every physician entering the practice of medicine in Ohio would have to pass an



examination. The general expense entailed in securing the passage of the law was \$225.25, which will be defrayed by the different schools of practice. The expense of the Society's committee was \$128.50. The committee extends special thanks to Drs. Coleman, Winders and Love for their valuable assistance which aided them so materially in their work. Report referred to Executive Committee.

Dr. Baldwin reported that the Committee on Malpractice had deferred operation, on account of medical bill.

Executive Committee reported through Dr. Forshay. The committee recommend that we do not contribute to the Rush Monument Fund; recommend that we contribute fifty volumes of the transactions of the Society to the Association of Medical Libraries. Report adopted.

Committee on Admissions made a partial report.

Committee on National Legislation reported that they had had one meeting and were progressing nicely.

Election of officers. Dr. Chapman, of Toledo, nominated Dr. F. D. Bain, of Kenton. Nomination seconded by Drs. Millikin and Coleman. The rules were suspended and Dr. Bain was elected by acclamation.

Committee on Nominations made the following report, which was adopted:

First Vice-President—Dr. J. S. Beck, Dayton.

Second Vice-President—Dr. A. W. Francis, Ripley.

Third Vice-President—Dr. L. B. Tuckerman, Cleveland.

Fourth Vice-President—Dr. Frank Warner, Columbus.

Secretary—Dr. J. A. Thompson, Cincinnati.

Treasurer—Dr. J. A. Duncan, Toledo.

Auditor Finance Committee—Dr. E. C. Brush, Zanesville.

Ethics—Dr. J. H. Rogers, Springfield.

Publication—Dr. Dan Millikin, Hamilton, O.

Legislation—Dr. T. M. Gehrett, Deshler.

National Medical Legislation—Dr. L. B. Tuckerman, Cleveland.

Admission and Medical Societies—Dr. N. S. Scott, Cleveland.

Growth and Prosperity—Dr. C. F. Clark, Columbus, O.

Dr. C. F. Clark offered his resignation as committeeman. Moved by Dr. Coleman that the present Committee on Legislation be retained. Carried.

Selection of place of meeting. The Academy of Medicine, Cincinnati, O., extended the society an invitation to meet in that

city next year. The invitation was accepted and Cincinnati was chosen as the next meeting place.

The President's annual address. Topic, "The Present Status of Abdominal Surgery." The author reviews the rapid strides made in surgery since its inception, and especially the progress in intestinal surgery in the last few years. There has been one great law established in intestinal surgery, namely, the earlier the operation the greater the chance of recovery. Does not think gastrotomy will ever become popular. It is generally believed that appendicitis is strictly a surgical disease. A few operations on the intestine for perforation have been successful, and opens a wide field for study.

A paper, "Diagnosis of Obstruction Due to Hypertrophy of Valves," by Dr. T. C. Martin, Cleveland. Obstipation is that form of obstruction in the rectum in which the valves interfere with defecation. Constipation is delay of feces, not due to obstruction. This is divided into six classes according to location and nature of obstruction. First, Valvular obstruction below sigmoid flexure; second, valvular obstruction at recto sigmoidal juncture; third, congenital juxtaposition or coaptition of rectal valves; fourth, congenital hypertrophy of rectal valves; fifth, true hypertrophy of rectal valves, and, sixth, fibrosis. The first is characterized by straining on passage of faeces; the second by long intervals between passages; the third by difficult passages in infancy and childhood, fluid and semi-fluid; the fourth by sudden establishment of defecation; the fifth and sixth by gradual development of defecation.

*Discussion.* Dr. S. B. Taylor: I think the Doctor forgot to mention one symptom, the inordinate desire to empty the rectum more. There is also pain almost constant in the iliac region referred to—the testicle in the male and the labra in the female. There is also a flattening of feces laterally.

A paper, "Report of Some Operations on the Intestines," by Dr. C. S. Hamilton, Columbus. The essayist reported four very interesting cases operated on for strangulation of bowels from hernia. Sums up the technique as: First, free access to the field of operation; second, rigid asepsis in every particular; third, temporary compression on each end of intestine; fourth, division of the intestine in healthy tissue; fifth, careful cleansing of end of bowels; sixth, union of mesentery.

*Discussion.* Dr. Larimer: Does not delay in seeking the aid of a surgeon in strangulated hernia. Does not wait until gangrene is established.

A paper, "The Diagnosis of the Position of the Foetus in Utero by External Examination," by Dr. E. G. Zinke, Cincinnati. In nine cases out of ten the attitude of the foetus can be determined at least ten weeks before parturition. The methods used are inspection, palpation and auscultation.

At 4 p. m., in the absence of Surgeon General of U. S. Marine Hospital Service Dr. Walter Wyman, Dr. Nicholas Senn, of Chicago, delivered his address on surgery. Dr. Senn's paper was entitled, "Compound Fractures." A compound fracture is one in which there is an opening into the fracture. The great risk in these cases is the danger of infection. It is this which marks the great distinction between open and closed fractures. The high degree that cellular tissue is prone to infection is well known. Antiseptic surgery has done much to prevent infection. Before asepsis 50 per cent. died. The real mortality now is 5 per cent. Under the old treatment primary union was seldom seen. Under strict antiseptic precaution, compound fractures heal as quickly as common ones. Subcutaneous fractures suppurate very infrequently. The surgeon who is most skillful in asepsis will be the most successful in practice. A simple fracture may become compound by patients trying to get around.

*Diagnosis.* If bone is exposed, or there is an opening, meddlesome exploration does harm. If there is a doubt in the diagnosis, give the patient the benefit of the doubt. The condition of peripheral circulation must be studied. The sensation must be carefully noted.

*Pathology.* Comminution of bone and medullary tissue. Very little hemorrhage, unless from gunshot wounds. Peripheral circulation may be interfered with by pressure of bone. Examine for foreign bodies. Look for fat embolism. Examine urine for fat; the less fat in the urine the less in the blood. To prevent necrosis of bone, supply moisture. If impossible, remove the bone. Primary infection presents in 24 hours. Osteo-myelitis and pyo-myelitis prevent bony union.

*Prognosis.* This is determined by extent of injury, loss of tissue, and duration of injury before surgeon is called. The danger of infection increases with time.

*Treatment.* Amputate when there is injury to structures so as to destroy the vitality of the parts. If an artery of any considerable size is destroyed amputate. In puncture and gunshot wounds scrub with alcohol, then 1-1000 bichloride solution. Do not explore fracture. Resection is seldom necessary. Avoid



suturing. In lacerated wounds, cut away the torn parts. The disinfection should extend to the seat of the injury. Drainage tubes may be necessary. Never entirely close the wound, but allow drainage. Apply a powder consisting of four parts boracic acid and one part salicylic acid, on a compress of cotton. Immobilise the part. Nothing is more harmful than meddling surgery. Rise in temperature within 24 hours denotes fermentation, after that time antiseptics. The tongue is the index. In fermentation it is moist, in sepsis, dry. If septic, remove dressing at once. If amputation is performed, it must be through healthy structures.

A vote of thanks was extended to Dr. Senn for his thorough and admirable address in surgery.

Adjourned.

Evening session called to order at 8 p. m.

Report of Committee on Legislation. Adopted.

A paper, "Pyloric Stenosis, Without Dilatation," by Dr. N. Stone Scott, Cleveland. It is strange how little this subject is understood. Osler is the best author on this subject in general medicine, and he does not mention hypertrophy of stomach. Symptoms same as in dilatation—vomiting, scanty urine, emaciation and acidity of stomach. The mistaken diagnosis of pneumonia, palpitation of heart and genito-urinary troubles are often made.

A paper, "Perforation Wounds of the Eyeball," by Dr. C. W. Tangemann, Cincinnati. In injuries to the eye the most important of all is injury to the eyeball, which often results in loss of sight by perforation of cornea. The most common cause is chips of metal striking the lid, incised wounds, etc. In many of these cases the workmen pick out the foreign body. These bodies should be removed by magnet. If these cases are not properly handled cataract may ensue as result of trauma.

Adjourned to Great Southern Hotel, where the annual banquet was held.

MAY 11TH—MORNING SESSION.

Called to order at 9 a. m.

Secretary's report of previous sessions read, corrected and adopted.

A paper, "Nasal Polypi in the Naso-Pharynx," by Dr. J. M. Ingersoll, of Cleveland. The author exhibited three specimens of very large polypi which he had removed from patients. Large

nasal polypi are extremely rare, as patients usually appear for relief from nasal obstruction before they become large. The symptoms are nasal obstruction, tinnitus aureum, difficulty in swallowing, purulent discharge, and partial deafness. Remove under cocaine anaesthesia, with cold wire snare. Hemorrhage usually slight.

A paper, "The Fraenkel Treatment of Locomotor Ataxia," by Dr. David I. Wolfstein, Cincinnati. The treatment for this affection has been so hopeless as to be worthy of any new method that might have a reasonable basis for improvement. Precision in diagnosis is away in advance of treatment. Our best chance of good results in the treatment of this disease is where muscular power is reserved. There is no specific to check nerve degeneration. Old methods have passed away. The employment of syphilitic treatment is disappointing. Organo-therapy has failed signally. Electricity in all its methods is palliative, but never curative. Massage has been much overestimated. Dr. Fraenkel's treatment is aimed at correcting the ataxia, and is of little value on tabes. The treatment consists in training movements, and improving muscular power and contraction by education and properly contrived appliances. In neurasthenics it does harm.

The Committee on Admissions made a partial report. Moved by Dr. Tuckerman that Dr. M. A. Love be reinstated to membership in this society with rebate of all back dues, including this year, for valuable service rendered in securing passage of Ohio medical law. Carried.

Dr. Wolfstein's paper discussed by Dr. Carpenter.

A paper, "Hydrophobia," by Dr. D. N. Kinsman, Columbus. The author was to have read a paper on "Diseases Recorded in the New Testament Which Christ Healed," but decided to substitute a paper on hydrophobia.

A paper, "The Treatment of Ulcers of the Leg," by Dr. S. S. Haldeman, Portsmouth. The author said the necessary thing to do was imitate nature by forming a scab. For this purpose he uses an ointment consisting of 1 pound powdered chalk, 8 ounces lard, and 1 ounce oxide of zinc, then bandage. Discussed by Drs. Means and Graefe.

A paper, "The Surgical Treatment of Haemorrhage Occurring in Ulcers of the Stomach and Duodenum," by Dr. R. J. Wenner, Cleveland. Dr. Wenner sums up the subject as follows: First, the severity of the haemorrhage does not indicate the degree

of ulceration; second, the time of vomiting has no constant relation to the location of the ulcers.

A paper, "Hip Joint Amputation," by Dr. W. D. Hamilton, Columbus. Dr. Hamilton reported five cases, with two deaths. He used the Wyck bloodless operation.

A paper, "Pelvic Suppuration," by F. F. Lawrence, was read. He reported that he had operated on 268 cases. He adopted the method best applicable to the case.

A paper, "Atypical Cases of Appendicitis," by W. J. Means, was read.

A paper, "Round Ligament Vento-Suspension of the Uterus; a New Method," by Dr. D. Tod Gilliam, Columbus, was read and operation illustrated by charts.

A paper, "Asepsis in Obstetric Practice," by Dr. J. N. Barnhill, Columbus.

Dr. C. A. Hough, of Lebanon, moved that this society extend thanks to the local Committee of Arrangements, to Dr. Doren, and to the profession of this city who added materially to the profit and pleasure of this meeting.

Adjourned.

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## Notes and Comments.

**Dr. E. O. Leberman** of Akron, was in the city on 12th of May.

**Dr. Frank E. Bunts** has returned from his trip through New Mexico.

**Dr. C. J. Aldrich** has removed his office and residence to 612 Prospect street.

**Dr. Hunter Robb** was in Washington for a few days during the month.

**Dr. S. W. Kelley** was rustivating at Brinkhaven, O., during the latter part of May.

**Dr. A. R. Baker** and family have taken up residence in their summer cottage at Villa Beach.

**Dr. and Mrs. B. O. Coates** are temporarily located in residence at White Hall, Fairmount street.

**Dr. and Mrs. George W. Crile** were expected home from their trip around the world on May 27th.



**Dr. William E. Lower**, accompanied the remains of Dr. M. G. Kolb to Detroit, on April 29th, where they were cremated.

**Dr. Charles L. Webster** is able to be out again after being confined to his house for two and a half months as the result of a street car accident.

**Dr. Wm. Nuss**, C. C. of P. and S., '99, whose term as house surgeon at the Cleveland General Hospital terminated on May 1st, is now located at the corner of Detroit street and Highland avenue.

**The Cleveland City Hospital's** house staff is now composed as follows: Dr. Herbert L. Tetlow, house physician; Dr. W. S. Crowell, first assistant; Dr. Charles E. Richards, second assistant; Dr. W. H. Williams, third assistant.

**The Cleveland General Hospital** now has the following house staff: Dr. H. C. Crumrine, house surgeon; Dr. N. E. Friedman, house physician; Dr. B. F. Hambleton, assistant house surgeon; Dr. Fred W. Linn, assistant house physician.

**St. Alexis Hospital** house staff is as follows since the 1st of May: Dr. A. P. Sculley, head of staff; Dr. Charles E. Ward, house surgeon; Dr. Thomas A. Costello, assistant surgeon; Dr. Asa F. Voak, laboratory work and outside medical cases; Dr. Myron Metzenbaum, inside medical work.

**American Proctologic Society:**—The following officers were elected by the American Proctologic Society at Washington, May 5, 1900. President, Dr. James P. Tuttle, New York, N. Y.; Vice-president, Dr. Thos. Chas. Martin, Cleveland, Ohio; Secretary, Dr. Wm. M. Beach, Pittsburgh, Pa.; Executive Council, Dr. S. T. Earle, Jr., Baltimore, Md.; Dr. A. B. Cooke, Nashville, Tenn.; Dr. J. R. Pennington, Chicago, Ill. Thos. Chas. Martin, secretary pro. tem.

**To Fight Love Bill.** The magnetic healers of the state recently met in Columbus in annual convention and perfected an organization to fight the enforcement of the Love medical law, which provides that all physicians in the state who begin practicing hereafter be examined by the state board.

Dr. Lewis H. Freedman, the Australian healer, who is at the head of the movement, says that sufficient funds have been pledged to carry the matter to the highest courts if necessary.

**The Tuscarawas County Medical Society** met at New Philadelphia Tuesday, April 24. The attendance was not as large as usual. After the usual business the society elected the following officers for the ensuing year: President, Dr. Nancy D. Richards, New Philadelphia; Vice-President, Dr. J. A. McCollam, Uhrichsville; Secretary, Dr. Martha Shalter, Canal Dover; Treasurer, Dr. S. R. Thompson, Uhrichsville. The time of the meeting was devoted to business and general discussion for the good of the society. The next meeting will be at Uhrichsville.

**Appointed Columbus Examiner for Medical Colleges.** Professor Charles E. Albright, principal of Central High School, was appointed the Columbus examiner for entrance to medical colleges in this vicinity at a joint meeting of representatives of the various medical institutions of the state and a committee of the State Medical Society at the Y. M. C. A Building Thursday morning.

The committee of the Medical Society was appointed to discuss matters of interest to medical colleges and universities and the qualifications of those entering these institutions, and the dates of opening the schools in the fall were discussed at this meeting. It was decided that the examinations in this city would be held early in October, simultaneously with those in Toledo, Cleveland and Cincinnati. Representatives were present from the following colleges: Ohio Medical University, Starling Medical College, Western Reserve Medical College, Cleveland College of Physicians and Surgeons, Cleveland Homeopathic College, Toledo Medical College, Medical College of Ohio, Miami Medical College and Cincinnati Eclectic College.

The meeting was the first of its kind held, and will hereafter be an annual affair at the time of the meeting of the Ohio State Medical Society.—*Exchange*.

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## Counter-Irritants.

"OLD COLLEGE BUILDING."\*

BY G. H. FITZGERALD, M. D.

How dear to our minds is the old college building,  
When fond recollection presents it to view,  
The battered brick walls and the deep worn stone door-step,  
The dark, dreary walls which as students we knew.

\*Written for the Meeting of the Alumni Association, Cleveland College of Physicians and Surgeons. Read at the banquet at the Forest City House, on the evening of May 2, 1900.

The small dirty office, the cracked marble mantle,  
The portrait of Miller which hung on the wall,  
The great blazing fireplace, the coal-scuttle by it,  
The janitor's bell on the door to the hall.  
The old college building, the fast crumbling building,  
The ram-shackle building now doomed soon to fall.

The chemical lab. with its stale old reagents  
And cheap muslin formulæ tacked on the walls.  
Pathologic lab. and the profs. private sanctum  
Where mice and small pigs gave their lives for the cause.  
The other labs., too, all so darksome and gloomy,  
In rooms so unfitted and in winter so cold.  
The rickety stairway, the soot covered ceilings,  
The huge coliseum where lectures they'd hold.  
The infected old building, the germ laden building,  
The foul smelling building, so decrept and so old.

How well to our mind now comes the odor  
Of the old college building of which we'd been told.  
With awe and what fear we first saw a cadaver,  
How we longed for fresh air and still tried to be bold.  
The old colored Jan, the bibulous Henry,  
Unique in his way, his deals hard to expose.  
A "bluff" without peer, and a natural actor,  
What a loss to the school only time will disclose.  
The ill-kept old building, the rat-haunted building,  
The barn-like old building which our memory knows.

The final "exams" and the cheap yellow paper;  
The "ponies" compiled with such scrupulous care,  
The vigilant Prof. and how deftly we fooled him,  
With close-written cuffs and the "reels" we'd prepare.  
The fellows who flunked and whose spirits we bolstered  
With ice-cold libations from a corner near by.  
The fortunate lads and that night of wild pleasure,  
The convivial boys whose nerve tension was high.  
The dirt-covered building, the smoke-begrimed building,  
The old Wooster building for which others may sigh.

The faculty then, and the many good teachers  
Whose free labor has made the great school of to-day.  
The ambitious hopes and the well nurtured plans  
Of the true, faithful band who served not for pay.  
The hard working doctors, the loyal professors,  
The friendly good men always cheerful and kind,  
The personal tales and the oft racy stories  
And forgotten advice which now comes to mind.  
The old college building, the well beloved building,  
The old Wooster building where a welcome we'd find.



# THE Cleveland Medical Gazette

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JULY, 1900.

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## Original Articles.

### APPENDICITIS—DIAGNOSIS AND TREATMENT.\*

BY ELMER G. MYERS, M. D.

Visiting Gynecologist to Aultman Hospital, Canton, Ohio.

The very fact that we have such a voluminous literature, so many articles in medical journals and such frequent obituaries in the daily press, impresses one, who gives the matter careful consideration, with the extreme gravity of this disease. It prevails at all ages and in all walks of life, spares neither sex, age, nor social position.

It should be taken into consideration that appendicitis is a disease curable in almost all cases if properly treated; and extremely fatal when not treated in accordance with modern pathology, and well grounded surgical principles.

Speaking of fatalities, it is estimated that each year fifty thousand people in this country are taken away by this disease. Not even to mention the suffering, the pain, and pecuniary losses to the afflicted, and those dependent on them, and the amount of time the patient is confined to home or hospital. This, indeed, is a sad picture, sadder, too, because it might have been prevented.

In hopeless malignancy, leprosy and other incurable diseases we may be pardoned for folding our arms, and in quiet resignation accept the inevitable; but in appendicitis it is different. In this we have not an incurable disease, but one amenable to proper treatment. I take it that the reason for the high death rate, the great pain and suffering, the detention from business is often times caused by physicians not familiarizing themselves with

\*Read before The North Eastern Union Medical Society, Feb. 13, 1900.

modern methods of diagnosis and treatment. The unfortunate ignorance of the laity concerning this malady, the obstinate patient, the waiting physician, who, too often, wishes to try his remedies a few days longer,—all these reasons, and many more might be named, but enough.

*Diagnosis:* Pain, in greater or less degree, is usually located at or near McBurney's point; however, pain in appendicitis may be located in other parts of the abdomen; even on the left side.

While it is asserted by most authorities that there is no prodromic symptoms, a number of my patients have been able to accurately foretell an exacerbation, or acute attack, by a soreness, and throbbing at the point of the location of the appendix; much like a modified thumping toothache according to their description. While I do not consider it of constant occurrence, it should be taken into account.

Vomiting is a usual symptom, though not always present. Temperature may be taken into consideration, but in most cases is of little value as a diagnostic sign, yet may be of more value as a prognostic sign; pulse gives more of an index to the patient's general condition than the temperature. Constipation is present in many cases, and diarrhoea the exception. The condition of the muscles of the abdomen usually gives a clear idea of whether the infection is confined within the appendix.

I have never seen muscular rigidity of the right side of the abdomen in cases in which the infection was confined within the appendix, but when infection has traveled beyond the appendix, and especially if the peritoneum be involved, rigidity of abdominal muscles is the rule.

I now come to palpation of the appendix as a most reliable means of diagnosis in the great majority of cases, especially in the early acute attacks, and in chronic appendicitis (catarrhal mucus inclusion cases). This method was first published by Edebohls some years since, but I feel sure it has not been thoroughly studied and practiced by the majority of physicians, and it is for this reason I call special attention to it.

*Description:* With the patient in a recumbent posture the abdominal muscles will usually relax sufficiently without flexing the legs.

First, standing on the right side of the patient, place the open hand on the right side over caecum, and maintain steady pressure for some minutes until the muscles no longer resent this means of provoking spasm, then, with the fingers a little to the



Fig. 1.



Fig. 2.





right of, and a little below the umbilicus with only moderate pressure, bring the skin outwards, as in Fig. 1, until they feel that they have passed over the right rectus; then, without losing hold on the skin, pressure is made downward, and slightly inward, enough to insinuate the finger tips beneath the rectus (Fig. 2), then the skin can be loosened slightly, next exert downward pressure until you can distinguish the pelvic brim, and feel the pulsation of the iliac artery (Fig. 3).

Now, it is well to call the left hand to our assistance (Fig. 4). "To maintain the pressure while the fingers of the right hand make note of what passes beneath them, slowly draw the examining fingers over the posterior wall of the abdomen to the right in the direction of the anterior superior spine of the ilium. We note successively the character of the various structures as they come beneath and escape from the fingers passing over them. In doing this the pressure exerted must be deep enough to recognize distinctly, during the whole route traversed by the examining fingers, the resistant surfaces of the posterior abdominal wall, and of the pelvic brim; only in this way can we positively feel the normal or slightly enlarged appendix; pressure short of this must necessarily fail. When this method is carefully carried out, the size and form of the appendix may be easily recognized." (Edebohls). Fig. 5.

Two points I wish to emphasize, to exert deep pressure just spoken of, to bring the skin outward as in Fig. 1, or the lack of redundant skin will greatly embarrass all the subsequent manipulations required in the search for the appendix. In some acute cases palpation may be impossible, in those having very firm and large muscles, or very thick abdominal walls. In the very muscular or obese an anaesthetic may be of great assistance; but as our experience in this method increases skill becomes more nearly perfect, fewer and fewer cases will be found where the appendix cannot be palpated. For our convenience we shall consider appendicitis under several heads.

*First.—Appendicitis due to a short meso-appendix.*

I have seen very little literature on this variety of appendicitis. The attack is caused by abrupt bending of the appendix when caecum becomes distended, thus imprisoning the secretions and bacteria causing symptoms of the disease.

Johnny H. This little boy had been suffering for several years. The diagnosis of appendicitis had been made by a surgeon in the west, who advised him to "have it cut out." Evidently this abrupt

manner of imparting good advice was not taken too kindly by the boy. He emphatically objected to an operation, and had an inordinate fear of doctors. When I first saw him I found him a tall and slender boy of 10 years, whose family history was negative except tuberculosis in one sister. Examination revealed a painful and enlarged appendix; a history of repeated attacks of appendicitis, in fact, a couch was always kept prepared for him at home as at any time or any place acute attacks of pain would come on. After being in a recumbent position for a longer or shorter time the pain would subside. I advised and performed an operation. Recovery rapid and complete. Fig. 6. No. 4.

Mrs. C., aged 36, mother of two children. Had very flabby muscles, in fact, she appeared to have muscles that were always in a chronic state of relaxation. About a year previous I had made a vaginal hysterectomy. From this operation she made a very good recovery. Some months after she began to go about she complained of pain in the right iliac region. This pain would come and go at irregular intervals. Examinations negative. I made a diagnosis by exclusion of either appendicitis or pain due to adhesions following the hysterectomy. Operation advised. An incision through the right rectus. In exploring the pelvic cavity I did not find a single adhesion, but found the caecum had shifted downwards and, with the appendix, was found well down in the pelvic cavity. They seemed to occupy the space recently occupied by the uterus and appendages. The appendix was almost six inches long, and for two-thirds of its proximal end had a very short mesentery. The conclusion was that the new environment taken by the caecum and appendix incident to anatomical changes following previous operation would, at times, produce such abrupt bending of this long appendix that its lumen would be mechanically obstructed, thus inducing the symptoms of appendicitis. Recovery uneventful.

Miss H. While being operated upon for removal of tubes and ovaries it was found that her appendix gave evidence of inflammation. The appendix had a very short mesentery; it was removed; operation was concluded in usual manner. On opening the appendix several points of ulceration could be seen.

*Second.—So called catarrhal or mucus inclusion caused by microbic infection, destruction of the mucosa, granulations, etc.* These cases are all produced by infection from within the bowels.

Nora L. This little girl was the daughter of a farmer, and eight years of age. I was called by her father to see her at her





Fig. 3.



Fig. 4.



home in the country, near Sandyville, Ohio. She was then suffering from one of her attacks. I found a very intelligent little girl, whose face only too truly portrayed the sufferings she had endured.

In brief, the history of the case is that for two or three years she had been having attacks of pain in right iliac region at intervals of a week or two to several months, in fact she was at this early age almost a confirmed invalid. She could neither visit friends nor attend school. Examination revealed an enlarged and painful appendix. I advised the parents to have her sent to the hospital for operation. To this they replied, "She may do as she wishes."

I explained to her in the simplest manner possible her condition as it was then, and what might be expected in the future, and what benefit an operation would be to her. Her answer was very emphatic, "I want an operation." When her acute symptoms subsided she did have her operation. Her recovery was about the smoothest I ever saw. She was a model little patient, and a lesson to many older ones. The lumen of the appendix was almost obliterated. She has been perfectly well ever since. Fig. 6. No. 5.

Miss K. I was called to see Miss K., Oneida, Ohio, while visiting in this city. I found her a plump and well nourished girl of 16 years. Her previous health had always been good, with the exception of slight dysmenorrhoea. I found her suffering excruciating pain, diffused over the entire abdomen. The history she gave was very indefinite, save that while feeling very well she was taken with pains in her stomach. By a little questioning, however, this was modified to a statement, that for some days she had had some uneasiness in the right iliac region, but as usual she and her friends attributed these symptoms to some indiscretion in eating. Pulse 130-140. Temperature 102. Vomiting, pain over McBurney's point. Diagnosis, appendicitis.

I had her removed to Aultman Hospital with the intention of operating if her condition did not improve. However, she continued to improve for about ten days; pulse and temperature became normal; had no pain when lying perfectly still, but when walking or sitting it would return, and these conditions continued without any improvement for two or three weeks. With the concurrence of Dr. C. B. Parker, of Cleveland, who happened to visit the hospital at that time, I decided to operate. Her recovery was uneventful.



Mrs. W. I was called to see Mrs. W., 26 years of age, married about three years. She had one child, which was still-born at eight months; family history good. During the past year she had had several attacks of severe pain in the right iliac region, usually lasting from four to five days, and occurring every four to ten weeks. The most severe attacks occurring at her menstrual periods. Hot fomentations failed to give much relief, and she was given hypodermic injections of morphia. Her appetite was not good, and she lost flesh rapidly. She could not walk erect, and when lying down was unable to extend the right thigh. A diagnosis of recurrent appendicitis was made involving the ovary and tube because of the increased pains during menstruation. I recommended an abdominal section, to which she and her family consented. The week following her menstruation, and following an unusually severe attack, an operation was made, after careful preparation at her own home in the country. I found the right ovary and tube acutely congested, and by dense adhesions firmly bound to the appendix. She made a smooth recovery. At the end of three weeks she had menstruated normally, could walk erect and extend the thigh with ease; appetite good, and felt so well that she insisted upon helping with household duties. Wound healed by primary union.

Miss E. W. Was called to see Miss E. W., of Shanesville, O. I found her a bright, stout looking girl of 15. Previous to the last year she had been perfectly well (except the usual diseases of childhood); she menstruated normally at 14. During the past year she had several attacks of pain in right iliac region, each attack being more severe than the last. Temperature 101-103. Pulse 100-120. Nauseated and occasional vomiting. She was unable to bear but slight pressure over McBurney's point. Uterus and ovaries normal.

Diagnosis of recurrent appendicitis was made and operation advised. I operated on her at her house. Found the appendix bound by numerous adhesions, severely congested lumen, almost obliterated at proximal end. Operation occupied but a few minutes, patient suffered but slight shock. Wound healed by primary union, convalescence smooth and comfortable. Fig. 6. No. 2.

Johnny G. I saw Johnny G., a boy aged 9 years in an acute first attack. He was suffering considerable pain, constipated and occasionally nauseated. Temperature 102. Pulse 120. I urged an early operation which was performed at his home in the coun-

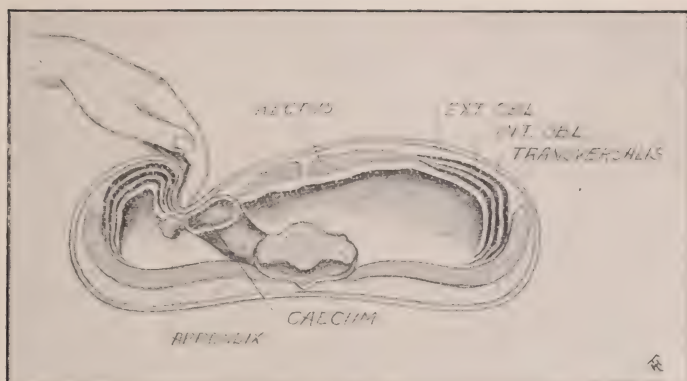


Fig. 5.



Nò. 1.      No. 2.      No. 3.      No. 4.      No. 5.      No. 6.

Fig. 6.



Incision on 10th day.

Fig. 7.





try the next day. Found the appendix about two inches long, the lumen almost obliterated near its attachment to the caecum. It contained a small quantity of pus, and very small fecal concretions. There was but a slight rise of temperature following operation, and he made a smooth, and rapid recovery.

*Third.—Gangrenous Appendicitis, including foreign bodies.*

On the morning of March 28th, 1899, I was called to see Mr. R., a young man of 22 years, as I was on my way to the hospital to operate on another case of appendicitis and gave him but a superficial examination, but made a provisional diagnosis of appendicitis. In the evening I saw him the second time. He continued to suffer considerable pain in the right iliac region. By palpation I could make out an enormously large appendix. I made a positive diagnosis of acute appendicitis, and now found that for several weeks he had occasionally had slight attacks of pain in the right iliac region; this he attributed to indigestion, as he was a chronic dyspeptic. I advised him to be operated the next day unless his condition was materially improved.

Shortly before 9 o'clock that same evening I was hastily summoned to the patient. About fifteen or twenty minutes before he had most violent pains, so severe he could scarcely endure it. I found that soon after I had last seen him the pains suddenly subsided (dead appendix), and he felt greatly improved. I found all the muscles on the right side of the abdomen very rigid, and an expression on the face told the story.

A diagnosis of perforated gangrenous appendicitis was made, and an immediate operation advised. He was sent to Aultman Hospital at once.

I opened the abdomen by a straight incision to the outer border of the rectus. When the peritoneum was incised fecal matter and fetid fluid flowed out. A portion of the omentum was gangrenous and infected. It was ligated and removed. The appendix was removed. It was gangrenous, perforated and contained two concretions, each as large as a hazel nut. I irrigated the peritoneal cavity with several gallons of normal saline solution and drained liberally with gauze. The operation was complete before 11 o'clock that night. His recovery was rapid for so desperate a case. He is in good health now. His dyspepsia disappeared upon the removal of his appendix. Fig. 6. No. 1.

Leonard G., 12 years old, was sent to my office with instructions to get something for the pain in his stomach. As I assumed it to be a little indigestion I prescribed accordingly. The next

day he returned to tell me that his pain was very much worse. An examination now revealed an indurated mass in the right iliac region. I sent him home, ordered him to bed, saw him next day; all symptoms worse.

At this visit I had him removed to Aultman Hospital for operation which was performed next day. I found the bowels and omentum all agglutinated into an almost unrecognizable mass, but by carefully separating the adhesions I came to a small pocket containing foetid fluid. The appendix was in an advanced state of gangrene; it was removed, the cavity carefully wiped dry and packed with a small strand of gauze, and the wound closed. Drains removed in a few days and not replaced. Wound was healed in two weeks. Recovery complete. Fig. 6. No. 3.

Miss S., aged 16 years, had been suffering several weeks with her first attack of appendicitis. I was called in consultation by her physician, found that she had pain in the right iliac region for several weeks, sometimes improving greatly for a day or so only to relapse in the same painful condition. A painful mass was discovered in the right iliac region, pulse accelerated and temperature elevated. A diagnosis of appendicitis was made. She was conveyed from her home in the country by train and ambulance to Aultman Hospital, where she was operated upon. After separating dense adhesions the appendix was removed in the early stages of gangrene. Her recovery was rapid and uneventful. Fig. 6. No. 6.

*Fourth.—Abscess Cases.* I was called by the attending physician on July 13th, 1899, to see Miss S., a very intelligent and intellectual young lady, aged twenty years. I saw her in her room at the Aultman Hospital for the first and only time previous to her operation. I learned that she was then in her third attack of appendicitis. Two years previous she had her first attack. This evidently formed an abscess, and broke into the bowels. From this she made a tedious recovery and, while well, she never got just up to par. Present attack was of about one week's duration. On examination I found the abdomen moderately distended, a well defined mass in the right iliac region exceedingly tender to pressure. Pulse 130 to 140. Temperature 104 degrees. Her general condition could scarcely have been worse. I advised immediate operation, in which I only concurred in the advice given by her attending physician. As soon as preparations were complete, and I insisted that all things should be ready for a very rapid operation, realizing that would be the only means of saving

the poor girl's life, I made a liberal incision through the sheath of the right rectus, parted the muscles or fibers with my fingers and opened the peritoneal cavity by rapid dissection. I found a large mass, in reality an abscess, covered by omentum with no adhesions to the anterior abdominal wall. When the free peritoneal cavity had been protected by sponges I opened the abscess with my fingers and several pints of foetid pus escaped. The abscess cavity was wiped dry with gauze, and not irrigated. No attempt was made to find or remove the appendix. The cavity was packed quite generously with iodoform gauze. No attempt was made to close the abdominal wound. At the close of the operation, which lasted but a few minutes, our patient was profoundly shocked. Her life for several days seemed to hang by a very slender thread but fortunately slowly recovered and is now enjoying the best of health.

*Fifth.—Appendicitis associated with diseased tubes and ovaries.*—Mrs. S., 25 years of age, gave a history of many spells of pelvic inflammation. Sent to me by her physician to remove diseased appendages. I found in addition a painful and large appendix, which was removed at the same operation. Recovery uneventful.

Mrs. K., of Pennsylvania, aged 32, had been a great sufferer from pelvic disease for years. Her appendix was found to be enlarged and painful and was removed with tubes and ovary. Recovery uneventful.

Mrs. C., aged 28, had two ovarian cysts of moderate size. While operating for this, I discovered appendix enlarged and containing a concretion. Her appendix was removed. Recovery uneventful.

Miss V., young lady of 20 years, had been an invalid for several years, anemic and nervous, bordering on hysteria. Dark coated tongue, foetid breath, menstruation irregular and scanty. Examination revealed diseased ovaries and retroversion, also enlarged and painful appendix. Operation advised and performed as follows: Curettage, plastic on each ovary, ventro-fixation, removal of appendix. Results—rapid and complete recovery. Pain and indigestion disappeared, feels perfectly well. I feel that her operation would have been incomplete without removal of appendix.

*Treatment.*—In a vast majority of cases it is my opinion operation is the only means of a definite curative measure, and that in skilled hands the death rate need not be more than one (1) or



two (2) per cent., while by so-called medical treatment it is estimated to be about twenty (20) to twenty-five (25) per cent., and I believe that the death rate in surgical cases will steadily be reduced when we have complete control of the patient from the onset of the disease.

As to medical treatment, we have no specific remedies for appendicitis. However, a few cases will be found that can be treated without operation, viz: When the symptoms of the disease are rapidly or gradually abating, especially in the first attack, and where the patient can be kept under observation. I think in many of these cases we can with perfect propriety wait.

I will report very briefly a few cases in which no operation was advised.

Mrs. M., 28 years of age, was seen the fourth day of her first attack of appendicitis. She stated that the symptoms had grown less during the last two days. Her recovery seemed complete after a few days. Examination a month later revealed a healthy appendix.

Mr. B., 18 years of age. First attack, symptoms steadily subsiding when seen, no operation advised. Recovery complete. Examination of appendix some months later showed it to be perfectly healthy.

George R., 15 years of age. Has had two attacks of appendicitis, each of a few days' duration. Recovery complete, no operation advised.

When the patient is seen early, say in the first twelve or twenty-four hours, very frequently a diagnosis can be positively made by palpation alone. In the treatment of abscess cases the same rule holds good as in abscesses in other localities. Some difference exists as to whether it is justifiable to search for and remove the appendix. Such authorities as Morris and Deaver insist on its removal; Wyethe and others advise letting it remain, as it is probable that disease has already disposed of it.

While I am very much inclined to be conservative in the removal of the appendix in pus cases, I believe the judgment and personal equation of the operator should have the greatest weight and should decide the matter. As for myself, I would not like to be bound by any hard and fixed rule. When I could safely remove the appendix I have done so in a number of cases; when its removal would jeopardize the patient's chances of recovery very much I have allowed it to remain. I have as yet seen no bad results from so doing. In all other cases the operation *par-*

*excellence* is the one that gives us an opening in the abdomen large enough to work conveniently and at the same time allows the normal re-assembling of anatomical structures.

No. 335 South Cleveland avenue.

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## A CASE OF ALLEGED MALPRACTICE.\*

BY J. H. SEILER, M. D., AKRON, O.

Mr. D. H. O., aged 60, laborer, short in stature, bow-legged, plethoric, with previous history of valvular heart trouble, cirrhosis of liver and rheumatism, drawing pension on the last named.

On February 28th, 1896, while working on a scaffold, about ten feet from the ground, lost his balance and fell down on a pile of bricks. Dr. C. C. Davison, of our city, was called and saw him a few minutes later. Seeing assistance was necessary, he hastily summoned Dr. F. C. Reed. After administering chloroform, a thorough examination was made.

They found a simple, outward, incomplete dislocation of the head of right tibia, with partial rupture of external lateral ligament, and possibly of crucial ligament. Both were fully satisfied that there was no fracture anywhere, nor injury in any other part of the body. The dislocation was reduced, and a temporary dressing consisting of heavy canvas cloth found in the shop was placed over it and secured, and the injured man removed to his home in an ambulance, a distance of about a half mile.

He was placed in bed and the temporary dressing removed. Instantly the tibia slipped out again as before, but when replaced was easily held in position. From the nature of the case, a single splint on the outside of the leg seemed best adapted to the case, whereupon a 16-inch shingle was whittled down to proper width, covered with cotton and wrapped with bandage.

The parts were then brought in apposition and retained by an assistant while the doctor applied the splint, padded it where needed, and placed his bandage over the whole. To make further secure in retaining position and quiet for limb, it was laid across a folded blanket, the ends rolled upon on each side and the whole securely strapped together.

The first few days there was considerable pain and swelling, necessitating readjustment of splint and bandage. By the end of a week and thereafter there was no more discomfort than is usual

\*Read before the Union Medical Association of Northeastern Ohio. Canton, May 8, 1900.

in such cases. However, the patient was so constituted that he bore his suffering with little grace and fortitude throughout the whole experience.

The doctor visited him daily for ten days, and all went well. Along about this time, when he called one morning he found the patient's wife had removed the dressing, cut down the splint about one-half and reapplied it in that way. The reason she gave for this act was that she thought she could make him more comfortable, notwithstanding the doctor's strict orders that the dressing should not be tampered with for any cause without first notifying him, which they agreed to do. Fortunately, no apparent harm came from it this time. The doctor removed the dressing, examined the limb, and applied another and larger splint, fortifying it with extra bandages.

The following week favorable progress was made to all appearance. However, the patient's wife informed the doctor that on two mornings previous, herself and a neighbor had redressed it, substituting strawboard for the wooden splint. The doctor, considerably chagrined at this interference, again examined the injury, and while there was no displacement manifest, yet the joint was very tender on pressure or movement. He again dressed it, placing his shingle splint over the strawboard, then repeated his charge, emphatically forbidding their meddling with the dressing or his getting up and moving about. Notwithstanding, a few days later the patient got up out of bed, and by the aid of a crutch started to walk across the floor. His toes caught in the carpet, and he fell headlong upon the floor. This did not cause displacement of the bones, but resulted in very severe pain in the joint owing to the strain. Splints and bandage were reapplied and he was content to remain in bed about five weeks from time of injury. He was then given permission to walk about the house by the aid of crutches. To give support to the knee, the doctor placed a snug bandage about the knee, and ordered him to wear this constantly for a while. The doctor did not visit him now, but the patient promised to advise him of any unforeseen trouble that might arise. Indirectly, the doctor heard that he was doing well, and going about daily. Everything was favorable, and the family satisfied with all that had been done.

About three weeks later the doctor met him on the street in his buggy. He asked to see the knee, which he showed him, but there was no bandage on it, and furthermore stated that he had not worn it. The head of the tibia was slightly crowded out, but the



tenderness had about all disappeared, and he seemed to have good motion in the joint, but there had evidently not been sufficient repair of the ligament to hold the parts in place, owing to the excessive and too early use of limb, rheumatic diathesis and other constitutional conditions.

Several weeks after meeting him on the street he called at the doctor's office to discuss compensation for damages instead of remuneration for services rendered him.

He claimed that the distinguished "Bone Setter" Reese, of Youngstown, and several prominent surgeons in Cleveland, told him that aside from the dislocation of the tibia, both bones of the leg and several small bones in the foot had been fractured, and the injury improperly managed.

Not succeeding in reversing the case with the doctor, he now started out to find a lawyer to help him press his claim. In this he met with considerable difficulty, as nearly all flatly declined him, stating he had no case. But he at last found a man who was willing to exhaust his legal talent in his client's behalf. The case was made up on the following claim for the plaintiff: "That he fell from a scaffold and broke, fractured and dislocated the bones of his right leg about one inch below knee, and because the defendant so carelessly, negligently and unskillfully set and dressed said injury, said leg is one inch shorter than before, tibia is out of place one and one-half inches, is crooked, became lame, and suffers much pain, lost time, all of which amounts to \$10,000."

Defendant proved by practically all the witnesses on both sides (including doctors of both schools) that there had been no fracture, no shortening of leg, tibia not out to exceed a quarter of an inch, had always been bow-legged, has suffered for many years from valvular heart trouble, cirrhosis of the liver and rheumatism, and has for a long time drawn pension based on his rheumatic trouble. That the short splint presented by them in court was ostensibly a substitute, roughly formed for the occasion, and that he is fully as able to work now as before the injury.

Prior to the opening of the trial, the counsel for plaintiff took his client and called on a number of physicians, propounding to them these pointed questions: "Is there anything the matter with that knee? Are the bones in place? Is it straight? Was it properly set," etc., etc., hoping thereby to get an opinion from the doctors, based on their statement of the case.

The first trial was before Judge J. A. Kohler, February, 1898. Notwithstanding the preponderance of evidence in favor of the

defendant, the jury returned a verdict of \$500.00 for the plaintiff. This the judge promptly set aside, as being contrary to law and evidence.

Meanwhile many indirect propositions for settlement were made by plaintiff's counsel, ranging from \$1,000 and costs to \$100 and costs, all of which were flatly declined. Failing in this, papers were made out for a new trial to the end that the "Bone Setter's" evidence and that of others might be secured. The date for trial was set and postponed so many times by plaintiff that the judge finally warned them if not prepared the next time he would strike it from the docket. An effort was then made to secure the "Bone Setter's" deposition, and to this end counsel and client, for both sides, made a pilgrimage to Youngstown, but very wisely he declined to be interviewed, so this profound evidence failed to materialize. Dr. George S. Peck, of Youngstown, gave them some valuable information as to the "Bone Setter's" professional qualifications.

Daunted in their effort to secure this much expected evidence, the case was again called before Judge Kohler, in February, 1900, and the trial lasted about one week. The evidence was practically the same on both sides, except that of the plaintiff and his family which was characterized by contradicting some of their former evidence, and stubbornly contending for some points which were easily proven different from their way of having it.

This time the jury brought in a verdict vindicating the defendant. The plaintiff made motion for new trial which was promptly overruled by the judge.

Among the legal fraternity it was intimated that this was to be a sort of test case, and upon the successful termination of this case depended the opening of three other malpractice suits.

The oft repeated slur that doctors are organized to protect each other in their shortcomings was hurled at the teeth of the medical witnesses, and even used as an argument against the defendant.

That the doctors of Akron stand together in their defence of justice and truth is a fact and necessity which cannot be gainsaid, because the exigencies of the case demand it, but that we do it to the end of shielding the members of our profession in genuine malpractice is a false imputation. In principle and practice we deprecate seeing our fellowlaymen, citizens of our community, made the victims of ignorance, neglect and imposition, and thoroughly believe in the culprit getting his just deserts, but when a doctor

who is honest, intelligent and attentive, does all for his patient that possibly can be done, falls into the hands of pirates, it is of the supremest importance that honorable, respectable men come to his rescue.

It is a common observation in every community to see the life and health of men, women and children jeopardized by the most flagrant practices of pretenders and ignoramuses, and yet they are allowed to go ahead in their nefarious business, unmolested and undisturbed.

It is also observed that a large percentage of the suits for malpractice are instituted against the most intelligent, conservative and conscientious men of the profession, men whose reputations are at stake, which goes to show that the motive actuating the suit is not to secure justice, but money, and the very idea that a man, or set of men may deliberately nag and harass the life of a doctor with no higher end in view than to extort money, is not only deplorable, but a serious reflection on the means of justice.

There should be no room for conflict between the legal and medical profession, and I don't think there is. Both are high, noble and indispensable, and if honorably and conscientiously followed, subserve the best interest of mankind.

But if dragged down to the level of a mere money-getting science, regardless of the happiness and welfare of man, then I see no reason why the lawyer should not be punished as well as the doctor.

#### JUDGE'S CHARGE TO JURY IN FOREGOING CASE.

Gentlemen of the Jury:—In order to ascertain definitely what the parties of this case respectively claim, we must look to the pleadings; that is, the petition of the plaintiff, the answer of the defendant, and the reply to this answer on the part of the plaintiff; and in this way we ascertain the questions to be decided.

The court must settle and determine all questions of law; and it is the duty as well as the right of the jury to determine and decide all questions of fact. I will, therefore, in order to be accurate, read, in your hearing, the pleadings. The plaintiff in his petition says:

"Plaintiff for his cause of action against the said defendant says that on or about the 28th day of February, A. D. 1896, he fell from a scaffold and broke, fractured, and dislocated the bones of his right leg, that the bones of said leg were fractured and broken about one inch below the knee. That defendant then was, and pretended to be, a regular practicing physician and surgeon. That



when plaintiff was injured so as aforesaid, said defendant was employed as a surgeon to treat said injuries, and to set and reduce the said fractured bones, and to place them in their proper place and position, and to place said dislocated bones in their proper place and position, and to attend to, and treat said injuries with skill, for a reasonable fee and reward; and said defendant then and there undertook said services; yet said defendant not regarding his duties in the premises, failed to place said dislocated bones in their proper place and position, and so carelessly, negligently and unskillfully set and reduced said fractured bones; and so negligently and unskillfully bound up, dressed and bandaged the same; and failed to use proper appliances, splints, and bandages to keep said fractured and dislocated bones in proper place, and so negligently and unskillfully dressed and attended to said fractured and dislocated bones and injuries, that by reason thereof, and of said unskillfulness, negligence and want of ordinary care and skill on the part of said defendant, plaintiff has, without fault on his part, become very lame, and has suffered and still suffers great pain, and has become greatly crippled in the use of his said leg, that by reason of said negligence, want of care and ordinary skill, on the part of said defendant, plaintiff's said leg has become crooked and about one inch shorter than it was before said injuries.

"That by reason of said negligence and want of care and ordinary skill, said injuries have become permanent, and plaintiff never will recover therefrom, and he alleges that if defendant had done his duty in the premises, and treated said injuries in a skillful or proper manner, he would have fully recovered therefrom. That by reason of said want of care, unskillfulness and negligence of defendant, plaintiff has lost his time and wages, and been rendered unfit to follow his usual work and occupation, to his great damage in the sum of ten thousand dollars.

"Wherefore the said plaintiff prays judgment against said defendant for the sum of ten thousand dollars, his damages so as aforesaid sustained."

To this petition of the plaintiff the defendant has filed the following answer:

"After leave first granted by the court to the defendant to file an amended answer instanter, the defendant for his first ground of defense says, except the averments in plaintiff's petition that the defendant is now and was on the 28th day of February, 1896, a regular practicing surgeon, and that on or about the 28th day of February, 1896, the said defendant was employed by the plaintiff

in his capacity as surgeon to treat said plaintiff for certain injuries sustained by him as a result of a fall from a scaffold, the defendant denies each and every averment and allegation in said petition contained.

"For his second ground of defense, the defendant avers that if the said plaintiff has become lame and suffered and still suffers great pain and has become greatly crippled in the use of his said leg and if the plaintiff's said leg has become crooked and is one inch shorter than it was before said injury, that said physical ailments and bodily condition are due solely to the negligence of the plaintiff in that the plaintiff neglected to exercise ordinary care in his treatment and use of his said leg and neglected and refused to obey the orders and instructions of this defendant as to the care, use and treatment of the same."

To this answer of the defendant the plaintiff has filed a reply as follows:

"Plaintiff for reply to defendant's amended answer, says, that he denies each and every allegation and averment contained therein, which in any way contradict or deny the allegations of his said petition.

"Plaintiff says that the bones of his leg are still out of place and dislocated, and were fractured; and plaintiff especially denies that his said physical condition is the result of or due to any negligence or want of care on his part; and he denies all other averments in said answer contained, which are not admitted to be true."

The rule is that whatever these parties admit to be true in their pleadings is to be taken by the jury as true, and no proof will be required in regard to all matters upon which the parties are thus agreed.

The answer of the defendant admits some of the statements contained in the petition. First, it admits that the defendant is and at the time the services were rendered, was a regular, practicing physician and surgeon; and it also admitted that on or about the 28th day of February, 1896, he was employed by the plaintiff as a physician and surgeon to treat the plaintiff for certain injuries sustained by him as the result of a fall. He also admits the dislocation of the bones of the plaintiff's right leg at the knee, but denies all the neglect, carelessness and unskillful treatment imputed to him; and he denies that any bones of the leg were fractured or broken. He avers further that he properly treated said dislocation, carefully and properly dressed and bandaged the

same; and he further denies each and every allegation in the petition not expressly admitted to be true.

This puts in issue every material fact stated in the plaintiff's petition, with the exception of what is thus expressly admitted to be true.

The amended answer sets out a further and second ground of defense to the plaintiff's action, namely, that if the said plaintiff has become lame and suffered and still suffers great pain, and has been crippled in the use of his leg, that if the said leg has become crooked and shorter than it was before said injury, that the said physical ailments and bodily condition are entirely due to the negligence of the plaintiff in that the plaintiff neglected to exercise ordinary care in his treatment and use of said leg, and refused to obey the orders and instructions of this defendant as to the care, use and treatment of the same.

The second ground of defense in the defendant's answer is what is called contributory negligence; that is to say, negligence and want of care on the part of the plaintiff, which caused or helped to cause the injuries of which he complains.

The plaintiff in his reply denies this allegation and generally denies everything stated in the answer, except such as are admissions of the plaintiff's petition.

It is incumbent upon the plaintiff to prove the acts of negligence or some of the acts of negligence set out and stated in the petition. In this respect the plaintiff holds the affirmative of the issue, the burden of proof being upon him, and he must, therefore, establish the truth of the material statements of his petition by a preponderance of the evidence.

In regard to the employment of a physician and surgeon, where one is called to treat disease or injury, the rule of law is, that a surgeon or physician who offers his services to the public impliedly agrees with those who employ him that he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by persons engaged in that profession, and sufficient to qualify them to engage in that profession. A surgeon assumes to exercise ordinary care and skill of his profession and is liable for injuries resulting from his failure to do so. The implied contract which the physician and surgeon thus enters into does not extend to an agreement that he will cure, but that he will employ such reasonable skill and diligence as are ordinarily exercised in his profession by the physicians. His obligation is that he will use ordinary care, and that he will exercise his best judg-



ment in the application of his skill to the case. He is not liable for an honest mistake or error in judgment, where there is reasonable ground for uncertainty.

The allegation of the plaintiff in his petition in this case is that the defendant in the treatment of his broken limb failed to place the dislocated bones in their proper place and position and carelessly, negligently and unskillfully set and reduced said fractured bones, and negligently and unskillfully dressed, bound and bandaged the same, and failed to use proper appliances, splints and bandages to keep the said fractured and dislocated bones in proper shape.

Now, if you are satisfied of the plaintiff's claim in this respect, touching the alleged negligence of the defendant and the failure on his part to exercise the care and judgment properly and reasonably required in a case of that kind, then the defendant would be liable for the damages proximately resulting from such negligent, careless and improper treatment; on the other hand, if the defendant in setting the limb and in his treatment thereafter used and employed the learning, skill, judgment and care ordinarily exercised by the medical profession in such cases, then and in that case the defendant would not be liable for the injury of which the plaintiff complains.

This, therefore, presents the first question of fact for you to determine; and, as I have said, the plaintiff must establish this claim of the want of ordinary skill, care and judgment by a preponderance of the evidence; and by a preponderance of the evidence is meant simply, that there is a greater weight of evidence on one side than on the other.

Perhaps I should define to you what is meant by negligence in this connection. Negligence is defined as being ordinary want of care, and may consist in doing something that ought not to be done, or in not doing something which ought to be done. By ordinary care is meant that degree of care which persons of ordinary care and prudence are accustomed to use and employ under the same or similar circumstances in order to conduct the enterprise in which they are engaged to a safe and successful termination. Negligence is the absence of care according to the facts and circumstances of each case. It is the failure to observe for the protection of the interests of another that degree of care, caution and vigilance which the circumstances justly demand. In measuring the degree of care you should regard the nature and circumstances of the case. The obligation to exercise care must be determined

in all cases by reference to the situation and knowledge of the parties and all the attendant circumstances. What would be extreme care under one condition of knowledge and one state of circumstances would be gross negligence with different knowledge and in changed circumstances. You should look, in the first place, to the nature of the injury to the plaintiff's knee or joint, the calling and business of the defendant, and what the situation and circumstances properly called for; and it is still ordinary care with reference to the case that the defendant impliedly contracted to employ, when called in as a physician.

Now, if in the light of the definition I have given you and the evidence in this case you find that the defendant in his treatment of the plaintiff's limb and the service which he rendered in that behalf, exercised the judgment, skill and learning such as good physicians and surgeons would ordinarily and usually exercise and bestow under the same circumstances, then that would end the case and your verdict should be for the defendant.

I have already stated to you that the burden of proof is upon the plaintiff to establish that the defendant failed and neglected to exercise such degree of care and skill as I have already spoken of and defined. And it must be also shown that the plaintiff's injuries, of which he complains, are a proximate result of the negligence, or some of the acts of negligence, so averred against the defendant.

On the other hand, if you find that the plaintiff's allegations in respect to the case are supported by a preponderance of the evidence, then you will proceed further and determine the question of damages proximately resulting upon the negligence, carelessness and unskillfulness of the defendant complained of, and in regard to that question, I will give you the rule further on.

It is a good defence to an action against a physician or surgeon for an injury sustained through a want of ordinary care and skill, that the plaintiff's own negligence contributed to the injury. It is the duty of the patient to submit to the treatment subscribed and to follow the directions given, provided they be such as a physician of ordinary skill would sanction, and if he neglected to obey the reasonable instructions of the defendant, he cannot recover damages, provided that you find from the evidence that such disobedience and negligence on the plaintiff's part proximately contributed to the injury which he alleges he has sustained.

You will therefore inquire as to the truth of this allegation in the defendant's answer, whether the plaintiff by his own want of

care and refusal to obey the orders and instructions of the defendant proximately contributed to the injury of which the plaintiff complains. The contributory negligence of the plaintiff in such case, however, in order to be available to the defendant must be such as that it has in some way contributed approximately to the injuries alleged to have been sustained. The presumption of law is that neither party was guilty of negligence or wrongful conduct alleged, and such presumption must prevail until overcome by the evidence submitted to you.

The rule in regard to contributory negligence is that if the evidence adduced and brought out before you by the plaintiff shows that the plaintiff himself was guilty of a want of care, or, in other words, of negligence proximately contributing to the injuries, then he must by evidence remove such presumption of negligence on his part; but where the evidence produced by the plaintiff does not raise such an inference of a want of ordinary care on his part proximately resulting in the injuries, then it is upon the defendant to show by a preponderance of the evidence that the plaintiff was guilty of such contributory negligence as is claimed and as I have defined. Where the plaintiff's evidence does not show want of ordinary care on his part, then and in such case the burden is on the defendant, and it must be made to appear to the satisfaction of the jury, by a preponderance of the evidence.

Taking up this case, then, inquire first, whether it is established by a preponderance of the evidence on the part of the plaintiff that the defendant, as a surgeon and physician, in the setting of this limb, and in its subsequent treatment and care failed or neglected to exercise such care, skill, judgment and learning as good physicians or as physicians ordinarily exercise in similar circumstances and cases. If you find in favor of the plaintiff upon this issue, and that the injuries which he sets forth resulted proximately and naturally from such want of care and negligence, then you will find for the plaintiff, unless you find also that the allegation of the defendant's answer is established by a preponderance of the evidence, namely, that the defendant by reason of the acts of negligence and want of care or some of the acts of negligence and want of care alleged in the answer are true. If you find that the defendant was guilty of negligence as I have defined it in the treatment of this limb, that he failed to exercise the degree of care and skill of the average medical profession in such cases, but that the plaintiff was also guilty of negligence and want of care proximately contributing to the injury, then and in that case he can-



not complain of an injury proximately resulting from such joint or combined negligence.

A number of physicians and surgeons have given their testimony and a number of them were allowed to testify as to their opinions. The general rule of law is that witnesses must testify as to the facts, that opinions of a witness in the matter are not admissible. There are, however, exceptions to this rule. One of the exceptions is in questions of science, skill, trade and the like, where it is competent to introduce what is called opinion-evidence; that is, a physician may testify as to the probable effects of physical injury, treatment of disease, setting of limbs, reducing of fractures, and so forth; and in some cases hypothetical questions were propounded to the witness and answered; that is to say, questions were put by counsel in which certain facts were assumed to be true and had been proven to the witness, and his opinion asked thereon, and such evidence has been given to you for the purpose of aiding you in fairly inquiring into and determining the facts of this case. You are not bound to accept the testimony or opinion of any witness in the case. You should carefully compare and weigh all the testimony, giving to each witness such degree of credit as such facts and opinions under all the circumstances may be justly entitled to.

I have a number of times, in the course of these instructions, used the word proximately, and by proximate cause is meant, cause by which a man of ordinary experience and sagacity could see what result would likely follow; that the injury was of such a character that it might reasonably have been foreseen and expected as a natural and ordinary result of the actual omission complained of. The injury must have been the direct and not the remote result thereof. The term is generally used in contradistinction of the term remote cause. The proximate cause of an injury is that which in natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury and without which the result would not have occurred.

On the measure of damages I give you the following rule: If the plaintiff has shown himself entitled to recover in this case, under the evidence and instructions of the court, he can recover only the actual damages that he has sustained, by reason of the injuries complained of; that is, such damages as will fairly compensate or pay him for the injuries he has sustained. But in estimating the compensatory damages in cases of this nature, all the consequences of the injury are to be taken into consideration,

future as well as past. The plaintiff, therefore is entitled to recover all damages which he has suffered up to the time of the trial, and for all damages which it is reasonably probable that he will sustain in the future, not exceeding the sum claimed.

In estimating the amount of such damages, the elements the jury is entitled to take into account, consist of all the effects of the injuries complained of, consisting of personal inconvenience, all bodily or mental suffering, disfigurements or permanent annoyance which is liable to be caused by the deformity, if any, resulting from the injuries complained of and the permanent impairment of the plaintiff's capacity or power to earn money in the future, if such is the case. In determining this last element you are at liberty to consider the health, condition and earning capacity of the plaintiff before the injury complained of, as compared with his present condition, in consequence of the injury, and how far the injury is calculated to disable the plaintiff from securing employment at his usual vocation or calling, or receiving money thereat or from engaging in those pursuits or callings for which, in the absence of the injury, he would have been qualified.

You may also consider the age of the plaintiff, his present health and his reasonable expectancy of life. The defendant, however, is liable only for such damages as result proximately from his failure to exercise that degree of care and skill ordinarily exercised and possessed by physicians and surgeons in the treatment of such cases. He is only liable for those damages resulting or accruing to the plaintiff on account of the injuries, in excess of those which would have accrued to him naturally from the dislocation of his limb, and he been treated with that degree of skill and care ordinarily possessed by physicians and surgeons. And further, the damages must be such as are set up and alleged to have been sustained in the petition, and such as have been proved, if any, upon the trial. And in estimating damages, should you come to that point, you should exercise a fair, candid and dispassionate judgment.

If you find for the plaintiff, you will estimate the amount of damages and write it in the blank space.

If you find for the defendant you will simply so indicate and sign by your foreman whom you will select when you retire.

## THE MODERN NURSE.

BY M. HELENA M'MILLAN, B. A., CLEVELAND.

So much is expected of the nurse of the present day that could any one member of the profession live up to these expectations she would indeed be a new and ideal woman.

Criticism of the nurse comes not only from her patients and their friends, who never fail to note and in due season comment on each characteristic, personal and otherwise, but also very freely from the medical profession. We are glad of this criticism, from both sources, and invite a continuance of it.

Listening year after year to reports received of nurses, one is apt to come to the conclusion that unless a woman has all of the following attributes, and many others, she is not a fully qualified nurse and may not expect even ordinary success in the nursing profession.

She must, of course, be a lady, perfect in manner and social customs, with soft voice and correct accent; she must have some accomplishments; she must be always bright and entertaining, well read, able to converse on the topics of the day; she must be nice-looking and spotlessly attired, must carry herself well and walk in the approved manner; she must abound in tact in dealing with patients, friends and physicians. She must be sympathetic without being too much so; assertive without being dictatorial; firm without being stern. She must be large, strong, absolutely untiring physically and mentally, and she must be lacking in human frailties of all descriptions. In addition to these, there must be the ordinary qualifications of thorough knowledge of her work, absolute truthfulness in carrying out details, loyalty to the physician during his absence—in short, she should be an accomplished woman of the world, a disciplined member of a sisterhood and finally a graduate of a school for nurses.

If a nurse choose institutional work she may be successful even if lacking a few of these desirable attributes, but not so in private nursing. Strange as it may seem, patients rarely complain of **failure in a nurse's work**—in the actual nursing for which she has been employed—but rather of some lack or unpleasing element in the woman's personality. In all trades and in all other professions but that of nursing the person employed is chosen for his ability to do one thing well, and provided he is qualified to accomplish satisfactorily the work for which he has contracted



he has the ordinary chances of success. This is not the case with the nurse. She may nurse in the most approved manner: her medical work may be correct and her surgical technique perfect, and still, with all this, she may prove to be a veritable failure.

It seems to follow from this that the "woman" is inseparable from the "nurse" and in that case the "woman," as well as the "nurse," must be trained. This is the question which now lies before the modern nurses' schools waiting to be solved. It is a problem in which we need the most kindly and generous consideration and help of the medical profession and the laity. It is the almost hopeless undertaking of forming untrained, unmatured and human women into self-sacrificing, broadminded, useful, perfected and trained nurses, within a limited time and in an atmosphere which is necessarily confining and narrowing to teachers and pupils alike. So far we have attained a limited success but it is questionable whether, with the present organization of nurses' schools (which too frequently are mere money saving devices for hospitals) we can accomplish more in the future than we have in the past.

In criticising the graduate nurse, therefore, it must be borne in mind that ordinarily she has been sent out from her school, with the assurance that she is a thoroughly equipped professional woman, while in reality the work has been only half accomplished. She has been drilled and perfected in the mechanical more easily acquired portion of the curriculum, but while receiving this, the fundamental "character training" has taken a very secondary place or even, at times, been entirely overlooked. Hospital work must, of necessity, be routine in character and, while this daily routine is essential in procuring successful practical nursing it does not tend to widen the woman mentally but has the contrary effect. If then, nurses are to be properly prepared for their life work, schools for nurses must be reorganized so that instead of developing the woman in one direction, they will develop her mentally, morally, physically and socially.

The young nurse, having completed her school course, is ready for private nursing. The true comprehensiveness of "nurse" may never have been pointed out to her or if it has been, she has not had time or opportunity to cultivate any but the practical side. Coming into contact with patients in their homes she realizes this incompleteness and also that, if she wishes to attain and hold an enviable rank in her profession she has no choice but to complete for herself the unfinished education. The task she

undertakes is an indescribably difficult one. The nurse is called to take charge of a very sick patient. She is on duty day and night, probably for weeks with a couple of hours' sleep daily; possibly she may get out for fresh air once a week; the treatment of the patient and the responsibility are constant; every moment is occupied. During this time she is subject to the patient's demands and caprice, to the criticism of the doctor, family and friends, to the petty annoyances of servants and a thousand and one other worries.

The doctor naturally expects her to be absolutely perfect in fulfillment of his orders, day and night—when at times she is physically and mentally incapable, from lack of sleep, of doing justice to the patient, the physician and herself; the patient expects instant response to his demands, regardless of the fact that these demands are incessant; the family expect cheerfulness, attention to their wishes, conformity to the customs of the house and so on—and all these things from a woman, who is working night and day, so constantly and under such a strain that she is in every way unequal to meet one and all demands, as they should be met.

No wonder that she fails to develop much morally, mentally and socially, and that at times she disappoints the medical profession and the public. It is amazing that women, on whom the public have made such heavy and unreasonable demands, have succeeded so well in satisfying the public. The success of the nursing profession has been bought at great cost—that of short life to the nurse.

That nurses, as a whole, have been successful is undeniable; that they have not been more successful is the fault of the school, of the public, and of the medical profession. The public is ignorantly and unthinkingly cruel in its treatment of the nurse, in its policy of twenty-four hours' work out of the twenty-four hours, in its decision that nothing shall be withheld, that the nurse shall give all—even to the utmost. The medical profession, surely neither thoughtless nor ignorant, is cruel in allowing this sacrifice, in its apparent indifference, in its failure to teach the public its selfishness, or to sufficiently support the nurse in her appeal for justice—not mercy.

Surely the nurse's petition is a modest one—merely that the public, that the medical profession will grant her eight or ten hours out of the twenty-four. She wants that time to be her own—not, as at present, to be compelled to accept as a grateful recip-

ient of charity—an hour or two begrudgingly given. The nurse wishes no charity. She asks as her right, merely time sufficient for sleep and for air, so that she, like the rest of humanity, may be reasonably well prepared for the work of the day.

If those on whose pleasure the nurse depends for employment will but recognize the fairness of this complaint and will do what is possible to procure for her necessary rest, it is all she asks. Given physical and mental freshness she can manage the rest of her difficulties. She is ambitious and will aim to satisfy to the utmost the demands of a fair public.

Should, however, it be found that this is still out of her reach the unequal struggle must be kept up. But, in such case, we ask that the critics may refrain from further criticism, that those who refuse to regulate fairly this unquestionable impediment to success may cease to make demands, which under the existing conditions are absurdly exorbitant.

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## THE ELECTRIC PRESSURE SOUND IN ANKYLOSIS OF OSSICLES AND DIRECT VIBRATION OF MEMBRANE TYMPANI.\*

BY SECORD H. LARGE, M. D., CLEVELAND, O.

Mr. President and Gentlemen:—My paper fortunately is not as long as the heading would indicate. I am not going to burden you with the etiology, pathology, etc., of ankylosis of ossicles and sclerosis of membrane tympani, but show you the instrument and cite some cases in which I have found it to be of great value.

Dr. August Lucae was the first to describe an instrument for direct mechanical vibration of the membrane tympani and from Dr. Lucae's instrument Dr. Lester, of New York, has given us the instrument which I show you to-night.

The instrument is a sound, on its end is a spiral spring with a hollow cone, this sound is adjusted to a motor which is run by two volts. Dr. Lester's directions for using the instrument are as follows:

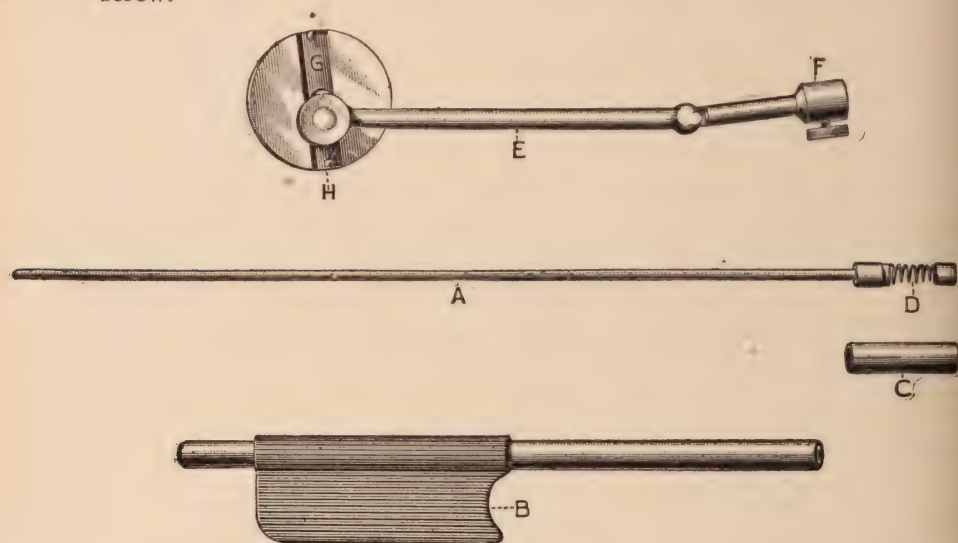
The head of the patient is turned slightly to the opposite side as for an ordinary examination of the middle ear, an ordinary sound speculum, which must not be too long, is introduced and canal illuminated, the right hand grasps the handle of the motor with the thumb resting on the button of the contact spring, the corrugated handle of the pressure sound is firmly held between the

\*Read before Cuyahoga County Medical Society at the May Meeting.



thumb and index finger of the left hand, the tip of the little finger is made to rest gently on the head of the patient immediately behind the auricle and the sound is introduced parallel to the anterior superior wall of the auditory canal until the cylindrical extremity of the spiral end rests upon the base of the short process of the malleus.

When contact is made vibrations ranging from five to fifteen hundred per minute are produced, the extent or length of the vibrations is controlled by the eccentric throw and the binding screw.



G—Eccentric throw. H—Binding screw. E—Connecting rod or shaft.  
F—Receiving Socket. A—Pressure sound and spiral spring (D).  
B—Corrugated handle.

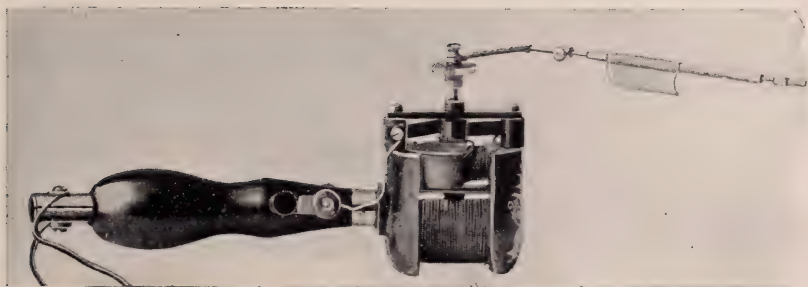
I have never used it further than a sixteenth of an inch from center. The length of treatment should be from five to twenty seconds.

The cone at the end of the spiral spring is hollowed out to better adapt itself to the short process of the malleus or to receive a pledget of absorbent cotton to prevent any possibility of mechanical injury.

You may get ankylosis of the ossicles and sclerosis of the membrane tympani from any inflammatory condition of the middle ear. In the following cases I have found the instrument of very great value:



Lester's Electric Pressure Sound in Position.



Electric Pressure Sound and Motor.





Case I. Miss B., aged 31, was referred to me in December of last year, she complained of deafness and tinnitus which had lasted for three years. Never had any discharge from ears and very little pain, had been under treatment for three years off and on and said she was gradually getting worse, particularly the tinnitus.

Examination: Canals normal, membrane tympani was cloudy and retracted, short process of malleus prominent, bone conduction good.

Tests: Watch, right ear heard at 3 inches; left at 6 inches. Loud whisper at 3 feet right ear, and at 5 feet left ear. Tuning fork C. at 5 inches in right ear and at 7 inches in left ear.

She had the pressure sound used twice a week for about ten seconds in either ear followed by politization and the mucous membrane of nasopharynx touched with following solution: Iodine grs. v, pot. iod. grs. x, glycerine ʒi.

On April 26th the following tests showed that her hearing had greatly improved and she had scarcely any tinnitus:

Watch, right ear 18 inches, left ear 22 inches. A gain of 15 inches in right ear and 18 inches in left ear. Low whisper at 3 feet in right and at 4 feet in left. Tuning fork at 12 inches in right and at 15 inches in left. The membrane tympani was not so cloudy and the short process of the malleus not so prominent. There was no pain in using the instrument.

Case II. Mr. H., aged 21, referred to me in January last, complained of deafness in right ear and tinnitus, said deafness had lasted for two years and was gradually getting worse, had never had any discharge from ear, but suffered from nasal catarrh.

Examination: Membrane tympani cloudy and retracted, light reflex lost, short process prominent and handle of malleus foreshortened, chronic inflammation of naso-pharynx of mucous membrane, hypertrophy of inferior turbinates.

Tests: Right ear, watch, at 4 inches. Loud whisper right at 4 feet. Tuning fork right at 7 inches.

Treatment: The pressure sound was used twice a week, followed by politization, applications made to mucous membrane of naso-pharynx and the nares. The knife of the cautery was run through the inferior turbinates once. On April 21st he heard watch at 9 inches, a gain of 5 inches. Low whisper at 3 feet. Tuning fork 13 inches, a gain of 6 inches. Tinnitus has entirely disappeared.

Case III. Mr. R., aged 29, referred to me in November, complained of deafness and tinnitus, which had lasted four years,

had been under treatment all that time, but said he was no better. The tinnitus was worse when he was lying down, he complained of anosmia (loss of sense of smell).

Examination: Canals normal, membrane tympani retracted in both ears, process of malleus prominent, light reflex lost, atrophy of mucous membrane of nose and pharynx, breath was very foul.

Tests: Watch at right ear 5 inches, left ear 4 inches. Voice loud whisper right 3 feet, left 2 feet. Tuning fork right 4 inches, left  $2\frac{1}{2}$  inches.

Treatment: Pressure sound applied to short process of malleus twice a week also to the mucous membrane of nose and pharynx followed by politization and applications tr. benzoine co. and boro-glycerine equal parts. The parts were first thoroughly irrigated with pot. permanganate solution.

Tests April 4, 1900: Watch, right ear 9 inches, left 10 inches. Voice low whisper right 4 feet, left 3 feet. Tuning fork, right ear 8 inches, left 9 inches. Tinnitus had entirely disappeared.

Case IV. Mr. S. complained of deafness in both ears, worse in right ear, duration four years.

Examination revealed all the results of chronic catarrh of middle ear.

Tests January 2, 1900: Watch, right ear 1 inch, left 5 inches. Tuning fork, right ear 3 inches, left 6 inches.

Tests March 30, 1900: Watch, right ear 7 inches, left 9 inches. Tuning fork, right 8 inches, left 10 inches.

Case V. Mr. L., aged 28, complained of deafness and tinnitus which had lasted for two years and a half, started from an attack of tonsillitis, had no discharge from the ears, but has had tinnitus for about two years, which has been getting worse. Had been under treatment during all the two and a half years, but says deafness was getting worse.

Examination revealed a typical case of chronic catarrh of middle ear.

Tests: Watch, right ear 3 inches, left 6 inches. Voice, loud whisper, right 2 feet, left 3 feet. Tuning fork, right 4 inches, left 7 inches.

Treatment: Pressure sound used twice a week, followed by politization and warm liquid vaseline injected through eustachian catheter. Local applications to mucous membrane of nose and throat.

On May 1st his tinnitus had disappeared and his hearing was greatly improved, as seen from the following tests:

Tests: Watch, right ear, 4 feet, left  $4\frac{1}{2}$  feet. Voice, loud whisper, right 3 feet, left 5 feet. Tuning fork, right 7 inches, left 9 inches.

From the above cases reported and from a great number now under treatment I feel satisfied that the pressure sound is of great value in certain cases of deafness and tinnitus, especially in those arising from chronic catarrh of the middle ear.

Of all the cases the instrument was used on there was only pain in one.

I have the Delstanch and the Laudenbaugh instruments, but have discarded them for the electric pressure sound.

The instrument is very useful also in atrophic conditions of the nose and throat in that it increases the vascularity and hence the nutrition of the parts.

*Room 1012, New England Building.*

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## THERMO THERAPEUTICS.\*

BY CHARLES H. CUSHING, M. D., ELYRIA, O.

Heat, variously applied, has been, for centuries, the great household remedy for all localized inflammation, as well as a most potent resource to the physician.

Modern scientific handling of this power in nature, as in electricity, is constantly widening its sphere of usefulness to mankind.

I have the names of thirty-three cases treated recently by hot air. I have used during the last year six different kinds of heating apparatus, none of which have been altogether satisfactory. The first two I used nearly set the patient on fire. They were too small. A large limb would come too close to the sides of the cylinder. The next one I tried was an ordinary Betz. In this one the heat came from the end instead of the center. A knee could not be heated without heating the whole leg, and the greatest heat would come at the wrong place. I had a second burner put in the center of this one which improved it. I next secured a larger apparatus in which both legs could easily be placed. I have never had any unpleasantness with this one except I could not bring the temperature above 300 degrees F. It took me a long time to find out that the kind of gasoline used made a difference.

\*Presented at the Northern Ohio District Medical Society at the meeting held at Elyria, 22d March, 1900.



I have had some very bitter experiences. To begin with the cases I will take first a man 45 years of age, weighing near 200 pounds. Good family history, but a personal history of occasional attacks of inflammation of the big toe. Patient claimed he was a plain eater, by this he meant he only took a moderate amount of wine, champagne and meat. He had, at the time of treatment, an inflamed knee joint, slightly reddened and tender, two inches difference in measurement as compared with the other knee. I put his leg in an apparatus where only the knee was exposed to the heat. The temperature reached 350 degrees F. when I discovered the toweling, in which the leg was wrapped, was afire. The apparatus was so small that the toweling around the leg came too near the cylinder. The patient was not burned enough to prevent putting his leg into a different machine in a few days. This treatment was followed up faithfully in his case, but I cannot state positively how much it modified and cut short this attack. I am skeptical as to its efficacy in this case. To differentiate the doctor's work from nature's work, considering the self-limitation of disease, is, fortunately for the physician, frequently impossible.

The next interesting case was an inflammation of the leg of traumatic origin. I gave the leg a good heating and this was the last I saw of him. The other day I heard he had made violent threats, stating I had roasted his leg in one of those "dofunny" burning machines.

Another marked failure was that of a man in the seventies. It was a typical case for this treatment. A subacute, articular and muscular rheumatism with considerable adhesions. I gave him repeated treatments, after which he had to walk several miles in the country in the cold. He left me worse off than when treatment was begun. Two months later he came in and paid his bill, and very courteously thanked me, stating he grew constantly worse until he stopped all treatment and had been gaining rapidly ever since.

The next failure was a barber with a pain in his left iliac and lumbar region. So much for the failures.

To begin with the cases more successfully treated I will take first a man with a bad ankle. Traumatic adhesion caused by an old fracture together with rheumatism, gave him an ankle that had cost him a great deal of suffering as well as money. The hot air treatment made his ankle feel the best it had since his accident. In five days he returned, stating if his ankle was not so much better he would sue me for the beautiful blister he had on

his heel. The benefit the intense heat did in this case was positive.

Another more marked case than this was that of a skeptical old fellow that I never knew to consult a doctor. To accommodate his wife, he came in to be experimented upon, as he put it. Rheumatism of the shoulder joint allowed but the slightest movement. After one hour's treatment he raised up his arm quite freely, and said "that beats h——." This man had been unable to work for weeks. With three treatments he was so much improved that he has continued work ever since. Another equally successful case was a boy 12 years of age who had been laid up the greater part of the summer with inflammatory rheumatism, leaving one leg flexed at an angle of 90 degrees. Medicines, liniments, etc., had no appreciable effect. Hot air treatment was given him for one hour every day combined with massage and passive motion, which was continued for several weeks. There was a constant positive improvement. To-day he uses the leg nearly as well as ever.

A man with a sprained ankle came limping into the office with crutches. After one treatment he walked off freely on his foot stating that it felt as good as ever. I will not at present go into the rest of the cases. The list includes acute, subacute and chronic muscular and articular rheumatism, gonorrhoeal rheumatism, traumatic synovitis, arthritis, teno-synovitis, sprains, inflammation from various causes, varicose ulcers, gout, fibrous ankylosis and perichondritis. It also includes a case of rheumatoid arthritis and one of syphilitic nodes. The hot air treatment of the last two cases was a failure. All of these cases, except those reported as failures, were either benefited or cured. In most of them relief followed the first treatment. Summing up these thirty-three cases 80 per cent. have been relieved or cured.

Considering the intractable nature of most of these cases under the usual methods of treatment the question arises: Is the hot air treatment receiving at the hands of the profession the recognition to which its merits entitle it?

*Johnson Arcade, Elyria, Ohio.*

## REFLEX LESIONS OF THE ORAL CAVITY ASSOCIATED WITH PREGNANCY.\*

BY F. A. McAULEY, D. D. S., CLEVELAND, O.

Mr. President, Gentlemen of the Northern Ohio Dental Association: In selecting this subject it is not my object to cover the field or to tell the numerous lesions which are caused through the reflexes during utero-gestation, but to trace as far as possible the sympathetic relation and certain disorders of the teeth, depending upon functional disturbance or structural lesions located in some remote part of the general organism, premising that a better understanding of the laws of reflex action and a more familiar acquaintance with nerve function and a clearer insight into the reciprocal or mutual relation existing between widely separated regions would lead to a more trustworthy view of the causes of sympathetic disorders of the oral cavity, the origin and nature of which we, as professional men, know very little about.

The thought which occurs to the profession, both dental and medical, is that as utero-gestation is an indisputable physiological act it would not give rise to such irritation as would produce sympathetic affections of the teeth, and this would undoubtedly be true if the utero functions were normally performed, but as the reproductive act is usually a conscious one, leads on to the conclusion of functional derangement, for the senses are oblivious to the normal processes of organic life. Therefore, no person in perfect health is supposed to have through the medium of common sensation or mental perception any knowledge of a brain, heart, lungs or uterus. The frequency of oral disorders, associated with pregnancy is in itself a presumptive evidence of a general disturbed uterine function more or less severe in character. Let us examine into the general accepted theory of certain pathological states of mouth during gestation. The universal view, I believe, is that there is more decay of the teeth during this period, which is due to the increased consumption of lime-salts incidental to vital growth and development, and this superadded draft upon the calcific elements of the material circulation, by divesting the lime-salts from the teeth, impairs the integrity of the latter, producing a nutritive lesion characterized by diminished ossific deposits, and a corresponding domination of animal constituents, thereby producing a softening condition rightly supposed to favor decay. This theory would seem that the assumption of the bone-producing

\*Read before the Northern Ohio Dental Association, at Cleveland, June 5, 6 and 7, 1900.



elements supplied by the ingesta are in the unimpregnated state largely, if not wholly, appropriated by the tissues into which they enter as a component, that there is not ordinarily any adequate provision for the excessive demands of a process of a Divine ordination and when the exigency occurs it becomes a simple question of divide between the mother and fetus.

H. J. Weiske, "The substitution of strontium for lime in the animal organism." Haselhoff theorizes that J. Koeing's researches prove that lime can be substituted in the animal organism. J. Weiske, on the contrary, notes that while strontium passes into the organs,—flesh, bones, etc., a physical organic replacement cannot be supposed. The administration of strontium is therefore physically unimportant. Does the continuous administration of acid mineral salts have an influence on the composition of bone? The author has previously shown that by continuous administration of dil.  $\text{H}_2\text{SO}_4$  to a food composed of hay and cereal, not alone the bones of the sheep suffer a noticeable diminution of mineral ingredients, but also the lime in the flesh of such an animal is influenced. According to Hintzman, as well as Hofmeister and Seidamgrotzky, lactic acid acts likewise. Weiske has also found that the administration of acid mineral salts, such as monosodium phosphate ( $\text{NaH}_2\text{PO}_4$ ) acts likewise. Only on teeth a noticeable difference could not be determined.

The researches on the influence which the addition of different salts to food have on the body weight and the composition of the bones and teeth. The action of  $\text{CaCO}_3$ ,  $\text{NaPO}_4$ ,  $\text{Ca}_3(\text{PO}_4)_2$ , and Na citrate acid were steadier as compared with monosodium phosphate. The important result of this extensive and tedious research was that oats alone as food, with the addition of  $\text{CaCO}_3$ , favorably influenced the development and composition of the rabbits' bones. The other salts conduct themselves indifferently or injuriously. The teeth here were less influenced than the bones, and, if the bones, the flat and the spongy the more.

G. Kobler: On osteomalacia. Examination of the ash of the blood from cadaver of a case of osteomalacia:

	Osteomalacia.	Normal.
$\text{P}_2\text{O}_5$ .....	7.25	8.49
$\text{SO}_3$ .....	16.04	6.85
Cl .....	19.925	29.59
$\text{K}_2\text{O}$ .....	34.16	25.565
$\text{Na}_2\text{O}$ .....	9.35	23.169
CaO .....	0.35	0.872
MgO .....	.....	0.512
$\text{Fe}_2\text{O}_2$ .....	12.85	7.86

Strontium cannot physiologically replace calcium in bone composition. This was held by Koing and others. According to J. Riidel: on the absorption and excretion of lime-salts in rachitic children, says, as a criterion for the absorption, the lime excretion through the urine was taken for 24 hours, according to Newbower, with ammonium oxalate and acetic acid and the oxalate weighed as sulphate. The research, conducted mostly on children, in the case of calcium oxide the lime in the urine increases from 80 to 126 per cent., therefore almost double of the amount administered, only 1 to 3.8 per cent., passed into the urine. Sodium phosphate diminishes the normal lime excretion 1-3 or even  $\frac{1}{2}$ . On the contrary the addition of HCl caused a slight increase in that excreted. Slowing of intestinal peristaltic increases lime absorption. Injections of calcium acetate, rabbit or dog, 12 to 34 per cent. appears in the urine again. Children were fed regularly with milk and bread and the calcium determined in the daily urine. In normal children variations occurred in the excretion within the limits of .002 to .005 CaO per kilogram. A milk with a specially high phosphoric acid cannot be obtained by the giving of calcium phosphate with the food. In the case of a milch cow a slight increase in phosphates in milk is only attained after three or four weeks of continuous administration of phosphate feeding.

Voit says calcium increases with increased administration, it however represents but 1 to 6 per cent. of that administered. While this might account for the increased sensitiveness of tooth bone due to mechanical or chemical stimuli where decay exists, it is hardly competent to explain the severe and distressing pain in teeth with unbroken structures which is clearly distinguished from hypersensitiveness, nor does it in any manner explain the various neuralgic affections coincident with impregnation. We will have to look further for some more rational solution of the causation as it relates to the oral phenomena with the reproductive processes. I believe a more plausible and defensible theory is due to the reflex lesions, structural or functional. In support of this theory I shall first ascertain if the organs of the mouth constitute an area correlated to the uterus through a medium of a sympathetic system of nerves.

The cerebro-spinal nerves are sent out from their centers in divisions or companies of seven and each company acts together and serves a common definite physiological purpose. These divisions are:

	Strands of cerebro-Spinal nerves.	Distribution.	Associated ganglia of sympathetic.	Main Distribution.
Area 1.....	Trigeminus, facial, etc.	Face and its orifices, anterior scalp.	4th cerebral.	Head.
Area 2.....	Upper 4 cervical.	Occipital region, neck.	1st cervical.	Head slightly to heart.
Area 3.....	Lower 4 cervical and 1st dorsal.	Upper extremities.	2d and 3d cervical and 1st dorsal.	Heart.
Area 4.....	Upper 6 dorsal.	Thoracic wall.	1st to 6th dorsal.	Lungs.
Area 5.....	Lower 6 dorsal, except last.	Abdominal wall, upper lumbar, upper lateral thigh and surface.	5th to 12th dorsal.	Abdominal viscera, tests, ovaries, fundus uteri and renal plexus.
Area 6. ...	12th dorsal and 4th lumbar.	Lumbar region, upper gleuteal anterior and inner thigh and knee.	1st to 4th lumbar.	Pelvic organs.
Area 7.....	5th lumbar and 5th sacral.	Lower gleuteal posterior thigh and leg.	1st to 5th sacral.	To pelvic organs and sympathetic supply being small.

With this distribution of the seven cerebro-spinal strands of nerves it is very easy to understand the causes of neuralgic pains associated with gestation. Consequently if the disturbance in the pelvic region were such as to produce a slight irritation, the reflex lesion of the pulp would manifest itself as a so-called sympathetic neuralgia caused by a pressure of the nerve fibres by an engorgement and distension of the blood vessels. Sympathetic neuralgia of the sound or unsound teeth which is very commonly associated with pregnancy cannot rationally be accounted for except in the manner here indicated.

In conclusion of this paper let us apply facts in explanation of the phenomena of softening and more rapid decay of the teeth during gestation. The lesion is purely a reflex one. Anything like habitual hyperemia of the vessels of the pulp must, by altering or diminishing the blood supply, more or less interfere with the nutrition of the teeth, would be in the direction of degeneracy or retrograde metamorphosis of tooth structure. The defective assimilation of ossific matter for purposes of repair, and certain diminished vital resistance to action of agents operative in producing solution of lime-salts. These are frequent complications coincident with pregnancy and are always more or less distressing and harmful and often involve the loss of valuable organs. This subject is therefore one of great interest to us as oral specialists.



# THE Cleveland Medical Gazette

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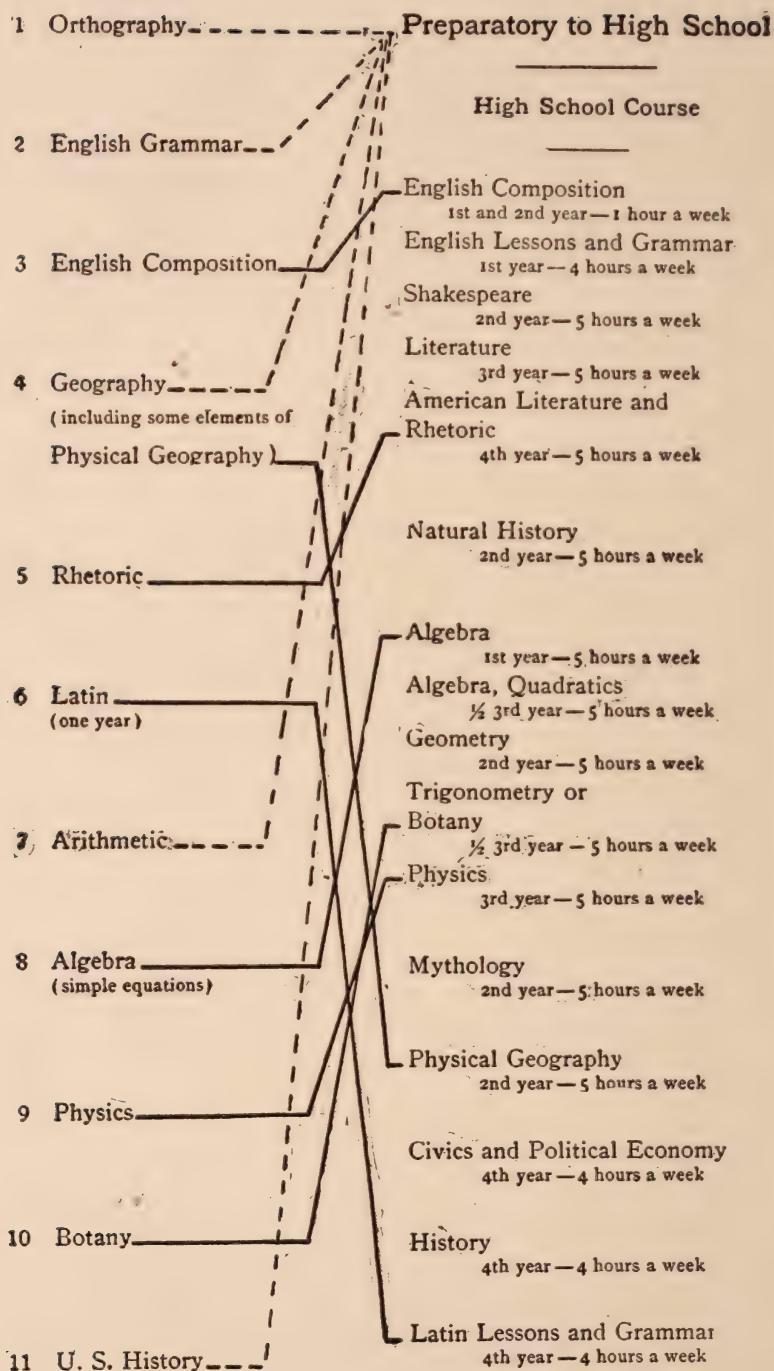
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## Editorial.

### WHO LET DOWN THE BARS?

After three decades and more of unceasing effort the medical profession of the State of Ohio have succeeded in securing the passage of a law requiring a preliminary education preparatory to the study of medicine. The new law provides that "in the application, as a condition of admission to the examination, he (the applicant) shall produce either of the following credentials:

a diploma from a reputable college granting the degree of A. B., B. S., or equivalent degree; a diploma from a normal school, high school, or seminary legally constituted, issued after four years of study; a teacher's permanent or life certificate; a medical student's certificate issued upon examination by any State Board; a student's certificate of examination for admission to the freshman class of a reputable literary or scientific college, or a certificate of his having passed an examination conducted under the direction of the State Board of Medical Registration and Examination." It was by no means thought by the medical profession that the State Board would venture to fix a standard less than the minimum standard provided in the law, viz., a diploma from a normal school, high school, or seminary, legally constituted, issued after four years of study. When, however, the circular issued by the Board came to hand, what was our surprise to find that the standard fixed for the examination covers not much more than one-third the work necessary to secure "a diploma from a normal school, high school, or seminary \* \* \* issued after four years of study;" that the prescribed examination for admission to the study of medicine was limited to the following branches: Orthography, English grammar, English composition, geography (including some elements of physical geography), rhetoric, Latin (one year), arithmetic, algebra (simple equations), botany, physics, and United States history. Arithmetic, English grammar, geography and United States history are no part of a high school course. They are prerequisites to entrance into every first-class high school in the State. The only high school studies, therefore, which are included in the examination are English composition, physical geography, rhetoric, algebra, physics, and botany. The high school course of our Cleveland High School—the English course—with one year of Latin in place of a one year optional in chemistry, physiology, astronomy or higher arithmetic, consists of English composition one hour a week for two years—equal to two hours a week for one year; English lessons and grammar four hours a week for one year; Shakespeare five hours a week for one year; literature five hours a week for one year; American literature and rhetoric five hours a week for one year (of which three hours are American literature and two hours rhetoric); natural history five hours a week for one year; first year algebra five hours a week for one year and second year algebra (quadratics) five hours a week for a half-year—equal to two and one-half hours a week for one year;





geometry five hours a week for one year; trigonometry (or botany) five hours a week for a half-year—equal to two and one-half hours for one year; physics five hours a week for one year; mythology five hours a week for one year; physical geography five hours a week for one year; civics and political economy four hours a week for one year; history four hours a week for one year—sixty-eight hours in all. Opposite, in the diagram shown, our readers can see at a glance what studies are included in the examination and what are omitted.

The studies included and omitted are as follows:

STUDIES INCLUDED.	STUDIES OMITTED.
English Composition.....2 hrs.	Eng. Lessons and Grammar...4 hrs.
Rhetoric.....2 hrs.	Shakespeare.....5 hrs.
Algebra.....5 hrs.	English Literature.....5 hrs.
Physical Geography.....5 hrs.	American Literature.....3 hrs.
Botany.....2½ hrs.	Natural History.....5 hrs.
Physics.....5 hrs.	Quadratics.....2½ hrs.
Latin .....4 hrs.	Geometry.....5 hrs.
	Mythology .....5 hrs.
	Civics.....4 hrs.
	History.....4 hrs.
Total.....25½ hrs.	Total.....42½ hrs.

It will thus be seen that the hours of recitation included in the examination prescribed by the State Board occupy in the high school course barely 25½ hours—37.2 per cent. of the whole course. In point of work, therefore, in the requirements of the State examinations for admission, nearly two-thirds of a high school course is omitted. In other words, the State Board of Medical Registration and Examination in their interpretation of the law have framed an examination which includes only 25½ hours of the 68 hours in a high school course, omitting 42½ hours—62.8 per cent. of the actual work necessary to secure a diploma representing “four years of study.” If this be a sin of ignorance it is hardly excusable on the part of a Board charged with such responsibility. If it be a sin of conscious omission it is a flagrant violation of the spirit of the law by a Board charged with the execution of the law. We cannot believe that Dr. N. R. Coleman, President of the Board, could have been a party to this nullification of the law. His record is too clear and too consistent in favor of higher medical standards to warrant that supposition. We can only suppose that he was out-voted. His record as

Chairman of the Committee of Minimum Standards of the National Federation of State Medical Examining and Licensing Boards precludes the supposition that he was a willing party to this evasion of the law. In his report of what the extent of such examinations should be he says\*: "Your committee would therefore recommend that so far as it be vested in the discretion of the State Examining and Licensing Boards, the rule be enforced that any college to be considered in good standing must demand as a minimum entrance requirement that the applicant possess a high school diploma or certificate issued after four years of study, or attain a satisfactory grade (75 per cent.) upon examination in the following branches, to wit: Orthography, English grammar, English composition, geography, rhetoric, Latin, arithmetic, algebra, geometry, physics, botany, zoology, and United States history, such examination to be conducted under the direction of the State Board having the authority, by certified examiners, none of whom shall be either directly or indirectly connected with any medical college." The extent of the examination to be:

"1. Orthography.—A sufficient number of words, and of such character as will be a thorough test.

"2. English Grammar.—Embracing the parts of speech, rules of punctuation, formation of plural and possessive, distinction of gender, classification and properties of verbs, and analysis of sentences.

"3. English Composition.—Two compositions of not less than 200 words each. One subject to be assigned and the other to be elective, the compositions to be written by the students at the time of the examination. They should be criticised in relation to thought, construction, punctuation, capitalization and hand writing.

"4. Geography—including some elements of physical geography; the political divisions; routes of commerce and travel; staple productions and population of the different countries.

"5. Rhetoric.—Rules and uses of rhetorical figures.

"6. Latin.—Two years, the examination showing the ability of the student to translate and parse the construction of easy Latin prose, together with the expression in Latin of English sentences, such as would indicate two years of study.

\*Bulletin of the American Academy of Medicine, Vol. 4, No. 2.

"7. Arithmetic.—Such questions should be submitted as will show a clear knowledge of decimal fractions, percentage, compound numbers, and square root.

"8. Algebra.—Through quadratics.

"9. Plane Geometry.

"10. Physics.—The questions to include the elements of mechanics, hydrostatics, hydraulics, heat, electricity, and especially optics and acoustics.

"11. Botany.—Embracing the structures of plants and the principles of their classification.

"12. Zoology.—Embracing general divisions of animal life, with distinctive conformations and habitat of each.

"13. United States History.—Boundaries and possessions of the United States, history of the early discoveries, by whom, and dates, mode of life of the natives, form of government from colonial times down to the present; various wars from the Revolution down to the present, causes of the same; conditions that led to the declaration of independence; federal constitution, form of government; various administrations; dates of the most important events under each administration; growth and wealth."

If the State Board had chosen to rise to the dignity of the opportunity "vested in the discretion" of the Board and had included in their examination the  $42\frac{1}{2}$  of the 68 hours which they omitted, they could have provided for one more year of Latin, five hours; quadratics, two and one-half hours; plane geometry, five hours; and zoology, five hours; thus filling up the full measure of Dr. Coleman's report on minimum standards and still have had left a balance of 25 hours to be assigned to Shakespeare, five hours; English literature, five hours; American literature, three hours; trigonometry, two and one-half hours; civics and political economy, four hours; chemistry, four hours; and general history, three hours. All this, in addition to their published requirements, would have just brought their standard up to the full measure of the minimum standard laid down in the law, viz: "a diploma from a normal school, high school or seminary, legally constituted, issued after four years of study."

But though the Board has failed to rise to the dignity of the occasion, and has contented itself with an examination so far below the plain intent of the law that ill-fitted men are still, permitted to begin the study of the most responsible of professions, it is no reason why the medical profession through whose strenuous efforts the law was enacted, should not, on their part, speak



in no uncertain terms as to what the law meant to them when they secured its enactment. If the present Board cannot enforce the law in letter and in spirit; if the examination prescribed by the law cannot in the hands of the present Board come up to the full standard of the law, it goes without saying, that having now the law, we must have a Board capable of enforcing the law. But the question, Who let down the bars?—and it took four men on the Board to do it—is of far less importance than the question of who shall now put them up. Of course a decision of the Board once promulgated must stand through the examinations of this coming fall, but it remains for the medical profession of the State of Ohio to see that never again shall the State Board of Medical Registration and Examination fall short of its full duty, and of its great responsibility.

L. B. TUCKERMAN.

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#### PAIN AS A SYMPTOM IN APPENDICITIS.

Unless one is very careful in eliciting from the patient the amount of pain and the location of it in appendicitis he is very liable to be deceived.

The patient usually has no fixed place in the abdomen to which he refers his pain, or, if he has, usually refers it to the umbilicus; and the umbilicus seems to be the place about which centers the pains and aches of nearly all the abdominal troubles in the average patient. The physician, in making his examination, should palpate the whole of the abdomen several times before he forms his opinion of where the greatest pain occurs; and in case the patient has appendicitis, he will find that while in the beginning the patient complains of pain all over the abdomen and apparently as great in one place as in another, yet on repeated palpation the greatest pain is over the McBurney point. But two things must be kept in mind. First, that pain over the McBurney point can be produced by something other than appendicitis, and second, that the absence of pain except to a slight extent over the McBurney point does not exclude appendicitis. A typhoid ulcer in the appendix has often been regarded and treated as a primary appendicitis, and this has happened not once but many times. The great abundance of lymphoid tissue in the appendix and the fact that typhoid infection occurs through this tissue makes this a field particularly prone to typhoid ulcer. Keen in his "Surgical Complications of Typhoid Fever" states that in all cases of operation for perforation from typhoid ulcer the surgeon

should examine the appendix with the view of removal, if diseased. Again, a beginning psoas abscess has fooled the very elect. But it is the absence of pain over the McBurney point that will obscure the diagnosis more than anything else. The appendix is a long and sometimes freely movable organ attached to the cæcum by its base and meso-colon. It is from three to six inches in length normally, but at times is so abnormally long as to reach almost any part of the abdominal cavity. It has been found under the liver, on the left side, in the posterior cul-de-sac of Douglas and is even so long sometimes as to project through the inguinal canal with a hernia, as the writer has seen on one occasion, the appendix being removed through this unusual opening and radical operation done.

Pain is a constant symptom in appendicitis. But one must not expect to find it always in the right inguinal region. Considered in connection with rigidity of the abdominal muscles and particularly with the conditions found on palpation of the appendix, a diagnosis can in the great majority of cases be made, particularly when psoas abscess and ureteral colic are excluded. But too much dependance ought not to be laid on this one symptom of this disease, and it ought to be considered always in connection with the other symptoms if accuracy in diagnosis is to be attained.

W. CLARK...

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### JOINT NATIONAL LEGISLATIVE COMMITTEE.

It is a source of congratulation to the Ohio State Medical Society that their plan of a Joint National Legislative Committee consisting of a committee of three of the American Medical Association, so conveniently located to Washington that they could be called together at any moment, and a committee of one from each affiliated society, was adopted by constitutional amendment as a permanent feature of the American Medical Association. When the plan was first broached by the delegates of the Ohio State Medical Society some four years ago there was a considerable doubt on the part of the Executive Committee of the American Medical Association whether this would not entail upon the association an unwarranted expense. The first meeting of the committee, held in Washington the 2nd to the 5th of May last, accomplished its business so satisfactorily to the association and at an expense so far less than had been hitherto voted to special

committees for the advocacy of special bills as to secure the unanimous approval of the Executive Board to the plan.

Moreover, the association has established in this committee a means by which the discussion of legislative measures—often crude and ill-considered when first proposed, can be permanently removed from the floor of the association until such measures have been thoroughly digested and so framed that they are in a proper form for action. The amendment to the constitution of the association was recommended unanimously by the Executive Committee and by the Board of Trustees, and, without a dissenting voice, became a part of the constitution. Questions respecting legislation which were brought up before this meeting of the American Medical Association were referred without debate to this committee, which will meet in due time, act upon them, and report not only to the American Medical Association but to each affiliated society at the same time, and thus the action of the medical profession of the United States upon measures in which it is interested will become a united action and not a divided one as has so often been the case heretofore. L. B. TUCKERMAN.

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#### THE FIFTY-FIRST ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The meeting of the national medical organization held this year at Atlantic City, New Jersey, was the largest and one of the most successful in the history of the association. The place of meeting was popular, well advertised, and accessible from the large centers of population in the Eastern and Middle States, thus insuring a good attendance. Atlantic City, early enough in the season to avoid the mosquitoes, is a delightful resort, with bracing ocean breezes and nothing to distract the attention from the meeting itself. There was some little complaint that the halls for the various sections were somewhat scattered, thus requiring a good deal of foot exercise on the "board walk," but that was a good fault. A worse fault was that some of the halls were noisy. However, the meetings in the sections, as well as in the general assembly, were largely attended, and excellent work was done. We cannot recall ever having known more extensive and interesting programs or heard better papers and discussions. The president's address was a model, and should be read by every doctor in the land. If that portion of it relating to the endowment of medical schools could be circulated freely among people



possessed of wealth great good might in time result. One of the features of this meeting was the pathologic exhibit, collected under the supervision of the unofficial committee on pathologic section, of which Dr. L. Hektoen was chairman.

The social instincts of the doctors and their friends had been duly provided for, and the various entertainments and receptions were well attended and enjoyed. Ohio's new medical law created a considerable interest and enthusiasm.

When it came to the election of officers it was found that there were three candidates for presidential honors—Dr. C. A. L. Reed, of Cincinnati; Dr. Charles Wheaton, of St. Paul, and Dr. William Osler, of Baltimore. Finally the following officers were elected: President, Dr. Charles A. Reed, Ohio; First Vice-President, Dr. A. W. Calhoun, Georgia; Second Vice-President, Col. Woodhull, U. S. A.; Third Vice-President, Dr. Philip Marvel, New Jersey; Fourth Vice-President, Dr. E. E. Quine, Illinois; Secretary, Dr. George W. Simmonds, Illinois; Assistant Secretary, Dr. A. M. Davis, Minnesota; Treasurer, Dr. Henry P. Newman, Illinois; Librarian, George Webster, Illinois; Trustees, Miles F. Porter, Indiana; E. Fletcher Ingalls, Illinois; W. L. Rodman, Pennsylvania; Joseph M. Matthews, Kentucky; Judicial Council, James R. Guthrie, Iowa; G. B. Mills, Tennessee; R. C. Moore, Nebraska; Ida J. Herberger, District of Columbia; John D. Roberts, Pennsylvania; Charles L. Rodman, Connecticut; S. L. Jeproei, West Virginia; oration on surgery, John A. Wyeth, New York; oration on State medicine, John W. Kober, Denver; oration on medicine, N. S. Davis, Jr., Illinois.

As to place of meeting—although Buffalo and other cities had been much talked of—the sole invitation from St. Paul was accepted and the association will assemble there next year.

The prophets are predicting a great success for the St. Paul meeting.

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#### CLEVELAND MEDICAL LIBRARY.

The library of the late Dr. Vance has been purchased by Drs. Allen and Hamann and presented to the Cleveland Medical Library. This collection consists of about two thousand volumes, many of them extremely valuable. They will shortly be placed on the shelves for inspection.

The Bureau of Nurses in connection with the library is daily adding to its members. There are now 34 nurses on its register.

Calls for nurses will receive prompt attention at all times. The bureau makes no charge for its services, and the profession and public generally are invited to make use of it when in need of a trained or experienced nurse of either sex.

The following nurses have placed their names on our register:

Miss Margaret Ockenden, Boston City Hospital Training School.

Miss E. Seymour, Lynn Training School, Massachusetts.

Miss Etta Z. Mills, Huron Street Training School.

Miss C. E. Meisterfeld, Huron Street Training School.

Miss Agnes McLeod, Huron Street Training School.

Miss E. Widdecombe, Huron Street Training School.

Miss E. Kiefer, Buhl Hospital, Sharon, Pa.; Maternity Hospital, city.

Miss J. M. Allen, University of Michigan, Ann Arbor.

Miss M. E. Kitson, Women and Children's Hospital, city.

Miss M. J. Hurdley, Harper Hospital, Detroit.

Miss M. E. Grant, National Emergency Training School, Chicago.

Miss M. Gleason, State Hospital.

Miss Agnes McIntyre, New York City.

Miss A. Reeve, Cleveland General Hospital Training School.

Miss C. D. Urban, Cleveland General Hospital Training School.

Miss A. C. Bagley, Cleveland General Hospital Training School.

Miss Sophie M. Cleugh, General Hospital, Kingston, Ont.

Miss J. Thomsen, St. Louis Training School.

Miss Betty Dorothy Patterson, Evansville, Ind.

Miss B. F. Arnold, Illinois Training School.

Mrs. M. E. Cook, Charing Cross Hospital, London.

Mrs. E. Schuler, Charity Hospital, city.

Mrs. Frances Mooney, Maternity Hospital, city; St. Magdalen's Hospital, Kansas City.

Mrs. J. Dennis.

Mrs. S. E. Davis.

Miss A. Britt.

Mrs. Rhoda Jones.

Mrs. Bernhardt.

Mrs. N. Winfield.

Miss A. R. Cone.

Miss M. Barlass.  
Mr. George H. Sanford.  
Mr. A. P. Askue.  
Mr. August Hagen.

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We would call the attention of the profession to the article, "The Modern Nurse," appearing in this issue of the GAZETTE. The article is from the pen of M. Helena McMillan, B. A., principal of the Training School and superintendent of nurses at Lakeside Hospital. Every member of the profession, whether they employ nurses or not, should read the article. The writer states that criticism of the nurse is invited, and for this purpose we offer the pages of the GAZETTE.

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## New Books.

ON DIABETIS MELLITUS AND GLYCOSURIA. By Emil Kleen, Ph. D., M. D.  
C Blakiston's Son & Co., Philadelphia.

This work is one of the many good translations presented to the profession in the last few years. Originally written in Swedish, it has been translated and edited by Dr. Eshner, of Philadelphia. Dr. Kleen's work at Carlsbad makes him well fitted to give a good exposition of so difficult a subject, a work that he has done well in this volume. He treats very fully of the geography, history, etiology, and symptoms of glycosuria and diabetes, distinguishing two forms of the latter according as the elimination of carbo-hydrates from the diet removes the glycosuria. If it does he considers the case a mild one, if not as a severe one. Bernard's theory of the hepatic origin of diabetes is believed by the author to be the most nearly correct one, although all other possible causative conditions are thoroughly discussed. The favorable outlook in gouty and the unfavorable in nervous cases are clearly brought out.

A rigid adherence to a non-diabetic diet is not advised in severe cases, as coma often results. The indications for the use of iodides, opium, arsenic, and bromides in this disease are clearly brought out. Altogether, it is a very excellent work upon this subject, bringing out all the latest views regarding so important a disease.

W. CLARK.



From Dr. C. J. Aldrich in exchange:

Kyle, D. Braden, M. D. A text-book of the Diseases of the Nose and Throat. 1899.

From D. Appleton & Co.:

Trans-American Laryngological Association. 1899.

From Dr. Stewart Leroy McCurdy (author):

Manual of Orthopædic Surgery. 1898.

From secretaries:

Transactions of the New York Obstetrical Society. 1898-9.

Transactions of the Louisiana Medical Society. 8 vols., 1888-1893, 1894, 1895.

From Association of Medical Librarians:

Donders, F. C., M. D. Anomalies of Refraction. 1899.

Duhressen, A. Practical Gynecology. 1895.

Gould, G. M. Student's Medical Dictionary. 1899.

Shaffer, N. M. Orthopædic Surgery. 1898.

Roberts, J. B. Fractures of the Radius. 1897.

Morris, H. Renal Surgery. 1898.

Morris, H. Human Anatomy. 1899.

Stohr, P. Text-book of Histology. 1898.

From Dr. Abraham Jacobi:

Festschrift in honor of Abraham Jacobi, M. D., etc., "International Contributions to Medical Literature."

Purchased:

Fenwick, Samuel, and W. S. Fenwick, M. D., Ulcers of the Duodenum and Stomach. 1900.

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## Society Proceedings.

ABSTRACTS OF PAPERS READ AT THE SECOND ANNUAL MEETING OF THE AMERICAN PROCTOLOGIC SOCIETY, WASHINGTON, D. C., MAY 2-3, 1900.

MORNING SESSION, FIRST DAY—PRESIDENT'S ADDRESS.

Dr. Jos. M. Mathews, Louisville: The bane of specialism of to-day is the "blooming out" of a class of men to practice specialties who have no practical knowledge of the same. Such action

should receive the strongest censure from the entire profession. I take it that the object of this assembling together is mainly to encourage the better understanding of the diseases of the rectum, by the reading of papers and the free discussion of the same. If you will permit me, I would suggest that the membership be made up of those who desire a better knowledge of proctological subjects, whether he be a general or special surgeon, a gynecologist or obstetrician. Indeed it is by the diffusion of such knowledge in a general way that the profession is to profit. Considered from a special standpoint it might be well to try and demonstrate that it is just as difficult to excise a rectum as it is to remove an ovary; that it requires as much surgical knowledge to anastomose the colon around a stricture as it does to sew up a lacerated perineum; to do a colopexia as to remove a fibroid tumor; or to do a colostomy properly as to do a trachelorrhaphy.

REPORT OF A CASE OF EXCISION OF THE RECTUM THROUGH THE VAGINA.

Dr. S. T. Earle, Jr., Baltimore: The case was one of adenocarcinoma; there were about five inches of the rectum removed, the centrifugal end of the rectum was drawn down, and stitched to the anal margin, the vaginal and perineal incision was closed and united by first intention. The results were most satisfactory, and the patient has fair control of her evacuations.

UNIQUE CASES OF RECTAL SURGERY.

Dr. Sam'l G. Gant, New York: *CASE I: Congenital Absence of the Coccyx and Lower Sacral Vertebra:* This case was referred to Dr. Gant to be treated for anal fissure. He was thirty years old and a very strong man. Examination revealed the absence of the coccyx and lower sacral vertebra which made the broad end of the bone stand out and easily noticeable through the skin because of the fact that the tissues below it were drooped, making a concavity large enough to hold a goose egg. He had been that way since birth but had suffered no inconvenience from it, having perfect control over his bladder and anus. The fissure was relieved by divulsing the sphincter, incising the rent, and stimulating it thereafter with a mild silver solution. *CASE II: Stricture of Rectum in a Little Girl Eleven Months Old Caused by Swallowing an Open Safety-Pin:* The case is of unusual interest because of the child's age. At the time the pin was swallowed it caused considerable pain and suffocation. It was passed imbedded in a mass of fecal matter just one month later. Several

days preceding this she suffered great agony and passed frequent and bloody stools. From this time on the child continued to have bowel trouble, suffering from constipation, occasional diarrhoea, and the discharge of pus, blood and mucus, with the stools. Digital examination revealed a tight stricture three inches above the anus which appeared to be the result of inflammatory action and adhesions. It was easily dilated with first one and then two fingers. The ulceration was curetted, the rectum irrigated, and the little patient sent home. After treatment consisted of stimulating applications and the occasional divulsion with the finger, this little patient was discharged cured in eight weeks. *CASE III. Closure of Artificial Anus of More than Three Years' Duration:* The left inguinal colostomy was made in the case of a young woman eighteen years old suffering from tubercular ulceration which would not succumb to less radical means. As a result of treatment, local and general, she fully recovered in a year, having in the meantime supported herself as a waitress. She desired the opening closed, but was advised to wait. Three years from the time the operation was made she became engaged to be married and insisted upon the closing of the opening in the side. Thorough examination demonstrated that the ulceration had healed and further that there was no constriction of the bowel. A number ten Wales bougie passed through the anus and out at the anal aperture in the groin. The opening was included in two elliptical incisions which were carried inward until the bowel was separated from the parietes. Because of the spur both legs of the original loop were firmly adherent and required resection. A purse-string suture was thrown around each, a Murphy button inserted and locked, and the gut dropped into the abdominal cavity. Peritoneum, muscles and skin were united with catgut. Primary union obtained, the button passed on the tenth day and the patient left the hospital at the end of three weeks. This patient made a complete recovery. She was under observation for two years after the closure and her bowels moved naturally during that time.

*SUBMUCOUS LIGATURE FOR HEMORRHOIDS.*

Dr. B. Merrill Ricketts, Cincinnati: A large needle is made to describe more than a semi-circle, carrying a moderate sized kangaroo tendon submucously around the varices which occupy the rectum as much as three inches above the muco-cutaneous border. The three hemorrhoidal vessels, arterial and venous, enter the rectum and perforate the rectal muscular tissue about



three and a half inches above the sphincter ani. Great difficulty has been experienced in passing the needle to complete the entire circle submucously. To overcome this the needle is brought out at a point corresponding to one-half of the circle, again to enter at its point of exit and then made to pass out at the point of primary entrance. In cases of but one or two hemorrhoids one ligature of this character is sufficient. If there are any hemorrhoids occupying the entire circumference of the rectum as many of these submucous ligatures may be applied as necessary. Then, too, it is **not necessary to incorporate all the varices within the ligature**, because many of those which are not so constricted by the ligature will become so as a result of the trophic changes which ensue. Sometimes it will be found most convenient to introduce all the ligatures before making them taut. By doing this the introduction of the needle is made with greater ease. Before this work is attempted the sphincter ani should be divulsed to the fullest degree with the finger. Divulsion once completed the hemorrhoids will at once protrude, and are most easily encircled by the ligature. As soon as the ligatures are made taut the hemorrhoids are inverted into the rectum. Sometimes it is desirable to puncture some of the larger hemorrhoids that the distension may not be so great and for the purpose of lessening the amount of hypertrophied tissue within the rectum. After a few weeks atrophy has taken place to such a degree as to allow the sphincter ani to resume its normal tonicity and to have completely destroyed all the objectional varices which formally existed. The advantages of this operation are: First, the impossibility of secondary hemorrhage; second, there is no tissue destroyed or sacrificed; third, the loss of time is but little, if any, greater than when they were removed by the clamp and cautery; fourth, thus far there has been no infection; fifth, there have been no fistula, abscess or fissures resulting therefrom; sixth, the pain is no greater, and less, perhaps, than in other methods of ligaturing; seventh, there is absolutely no stenosis.

#### TEMPORARY ARTIFICIAL ANUS.

Dr. Jas. P. Tuttle, New York: Indications for temporary artificial anus: First, obstruction with removable cause; second, in cases of excision of the rectum where sphincter is involved; third, in intractable ulceration of the rectum; fourth, in stricture of the rectum with large area of ulceration which does not yield to local treatment readily; fifth, in neoplasms in the sigmoid and colon that cannot be found through the rectum; sixth, in malfor-

mation's and imperforate rectums, where the gut cannot be easily found in the perineum; seventh, in chronic membranous colitis; eighth, in certain forms of recto-vasical, recto-vaginal and recto-urethral fistulas. With these numerous and clear indications, the operation is comparatively seldom recommended because of prejudice against it and the false impression that once one has an artificial anus he must always have it. Doctors hesitate to advise it, because they know that by the older methods closure was uncertain, and more dangerous than the operation or the disease for which it was made. The operation advised is a modification of the Rectus-Maydl method. It is quick, simple, effectual. The opening is made by a T-shaped incision so made that the transverse flap falls into the distal, and effectually closes it, while the two triangular ones roll outward and curl up like a dry leaf, thus leaving free exit from proximal leg of convolution. No part of the gut is removed or destroyed. Closure: The closure is made by simply unrolling and suturing back into position these flaps, first with sutures through mucous membrane, and then with Lambert sutures of chromicized catgut. After the gut is thus closed, the partial parietal peritoneum is dissected away for an inch or more all around the abdominal incision, so that the gut will drop back into the abdomen, but not into the peritoneal cavity, thus eradicating the spur. The muscular fascia and skin are then sutured over the gut with silkworm gut.

CHRONIC INTERSTITIAL PROCTITIS AS A FACTOR IN OBSTINATE CONSTIPATION AND ITS RADICAL TREATMENT.

Dr. J. Rawson Pennington, Chicago: He demonstrated that the sigmoid flexure in the distended state frequently extends into and occupies the right iliac fossa; also conclusive evidence of the existence of the rectal valve and its structure. He claimed that deformity of the rectal valve and hypertrophy of its muscular layers were the two principal primitive causes of obstinate constipation. He exhibited his automatic valve clip for dividing these structures when pathologic.

EVENING SESSION.

DEMONSTRATION OF THE RECTAL VALVES IN THE LIVING SUBJECT BY MEANS OF HIS METHOD OF PROCTOSCOPY.

Dr. Thos. Chas. Martin, Cleveland: Without the use of anesthetic by means of his chair the subject was put into a posture equivalent to the knee-chest posture, the rectum inflated and its entire length exposed to direct view. The rectal valves were ren-

dered conspicuously visible and palpable to the members of the society and the fact of their existence generally agreed upon by the society.

MORNING SESSION, SECOND DAY.

THE NEW RADICAL OPERATION FOR VALVULAR OBSTIPATION.

Dr. Thos. Chas. Martin, Cleveland: A normal valve may be effaced under the pressure of the test-hook. A valve situated on the fixed posterior wall of the rectum is much more obstructive than is one situated on the anterior wall for the reason that the descent and backward excursion of the anterior rectal wall places the feces more securely in the pocket afforded by a posterior valve. A valve situated on the anterior wall if of the same condition and dimension as one situated on the posterior wall is less obstructive to defecation for the reason that the backward and downward excursion of the rectal wall throws the feces out of the valve pocket and over its free border. If the number of valves be more than the normal three it can be readily understood that such an addition of obstructive features increases the obstruction. For instance, four or five relatively shallow valves placed close together are more obstructive than are two somewhat deeper valves if these two valves are placed some distance from one another. Anatomic coarctation or physiologic juxtaposition of the valves may contribute to the establishment of obstipation whether the valves be diseased or not. If two valves are so closely situated that their borders are seen to overlap, or if it is seen that on the patient's bearing down two valves then overlap, it may be assumed that these valves constitute an obstruction to defecation. A valve situated at a direct right angle to the axis of the rectum is more obstructive than one that is obliquely situated. However, an oblique valve may contribute to the establishment of an obstruction in a transverse valve immediately below it for the reason that the oblique valve may deflect the fecal column directly into the pocket formed by the next lower and transversely situated valve.

- (1) The resistance which any given valve affords to the test-hook;
- (2) propinquity of other valves to a given valve, and (3) the direction of the valve next above a given valve, together with (4) the number of valves in the rectum, and (5) the precise situation and direction of each valve are all features which should be studied as possible component factors which contribute to the obstipation. Hypertrophy of the rectal valve due to a rectitis, local or general, is characterized by evident thickening of the free border of the valve. Fibrosis of the rectal valve is not character-



ized by an increased size of the valve though its resistance to the hook may be as great as in the case of the hypertrophied valve. There is always noticeable in cases of valvular obstipation a very conspicuous redness of the mucous membrane which begins at the obstructing valve and extends downward toward the anus. The rectal mucosa above the obstructing valve is usually of pale complexion except in those cases where there is invagination of the upper gut. Dr. Martin then outlined his operation for division of the valve and detailed the precautionary measures to be employed to ensure safety and secure success.

#### MOOTED QUESTIONS IN PROCTOLOGY.

Dr. A. B. Cooke, Nashville: He called attention to a number of more prominent points of disagreement among proctologists. These were: (1) Anatomy: The existence of the rectal valves not yet generally admitted, when in truth they constitute the most conspicuous features of the normal rectum. (2) Physiology: Many points in this connection yet to be worked out. The mechanics of defecation a much disputed subject. (3) Pruritis Ani: Is this a disease or merely a symptom? The etymology of the term itself offers the readiest solution of the problem. Pruritus means simply *itching* and itching cannot be regarded as other than a symptom. Though sometimes difficult to locate the lesion which gives rise to it is practically always a macroscopic one. In searching for it the reflexes are to be borne in mind. (4) Simple Ulceration: One prominent author (Mathews) states that this disease located above the sphincter ani muscle is a very uncommon one. Dr. Cooke's experience had been the very opposite. The difference of opinion is probably due to different conceptions of the meaning of the word. Properly considered, ulceration and ulcer are synonymous terms, and the rectal ampulla a frequent site of such disease process. (5) Benign Strictures: The author called attention to the different views held as to the frequency of syphilis as a causative factor. Sixty per cent. is far too high an estimate. The rectal valves have much to do in etiology of this disease. (6) Cancer: Discussion of this disease was limited to the question of the justifiability of colostomy as a means of prolonging life and giving comfort. As compared with the hypodermic syringe the author deemed it greatly to be preferred, and when total extirpation was impossible strongly advised resort to this procedure.

## PRURITUS ANI, WITH ESPECIAL REFERENCE TO ITS LOCAL TREATMENT.

Dr. Lewis H. Adler, Jr., Philadelphia: It is important to see that the patient has a daily evacuation of the bowels, and if necessary, medicines are to be used for this purpose. In all cases, more or less varicosity of the hemorrhoidal vessels exists; at all events I am in the habit of seeing the patient daily for a time, and I employ an injection of one or two or two and a half drachms into the cavity of the rectum of the following prescription: Fluid extract of hamamelis, 1 fluidounce; fluid extract of ergot, 2 fluidrachms; fluid extract of hydrastis, 2 fluidrachms; compound tincture of benzoin, 2 fluidrachms; carbolized olive or linseed oil, 1 fluidounce; (carbolic acid, 5 per cent). Mix. Sig. Shake well before using. The patient is advised prior to using this injection that a desire to have the bowels evacuated will occur as a result of its employment, but that if he will remain quiet upon the examination table, the sensation will quickly pass away. I paint the entire surface around the anus for several inches outward with a strong solution of nitrate of silver. If any break in the continuity of the skin exists as a result of previous scratching, a little of a 2 per cent. cocain solution applied to the abrasion, will prevent the suffering incident to the use of the silver salt. In my experience the use of a strong silver solution is not nearly so painful, under the circumstances surrounding its use in the class of cases under consideration, as the weaker solutions. So soon as the silver has dried and from the first visit and thereafter, I smear over the anus and the cutaneous surface of the parts for a distance of about two inches around the orifice, the officinal citrine ointment or unguentum hydrargyri nitratis. The ointment, I use in its full strength. Over the salve I place a wad of absorbent cotton, the quantity of cotton varying with the patient's wishes and comfort. The dressing is kept in place with a T-bandage. If the itching should annoy him during the night he is directed to bathe the anus with hot water, as hot as can be borne with comfort, but under no circumstances is he to rub the parts. He is also told that the application of the hot water will momentarily increase the itching, but that he is not to scratch. After he has used the water he is directed to use either a solution of black wash, lotio nigra, or what is better in some cases, calomel ointment, either of which is to be applied locally to the affected parts.

## FISTULA.

Dr. Geo. B. Evans, Dayton: The efficacy of all remedial

measures except the knife for curing fistula still remains unquestioned, unless by inaccurate observers. A fistula which is not due to ulceration and perforation of the rectal wall from within is the result of a previous abscess, due to an inflammation, and that the result of traumatism. I have found sometimes fistula due to caries of the lower portion of the sacrum and coccyx. I believe it to be a safe rule to operate on phthisical patients as upon others. During the past ten years there have been over six hundred phthisical patients admitted to St. Elizabeth Hospital, Dayton, O.; during the past six years I have operated upon 198 cases of various rectal diseases in the charity wards; 42 have been for fistula; 7 of the 42 have been without doubt tubercular. Two of the 7 died after several months' comparative comfort.

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### Notes and Comments.

**Dr. Ralph C. Pease**, of Chardon, was in the city on the 26th.

**Dr. Norman C. Yarian** spent two weeks in Washington, D. C., during June.

**Dr. Edward S. Lauder** was out of the city for a few days during the month.

**Dr. William E. Shackleton** was married on 13th June to Miss Martha McGarvin.

**Dr. and Mrs. Harry C. Luck**, spent a few days at Oak Ridge during the latter part of June.

**Dr. Wm. H. Nevison** has returned to the city after spending the winter in New Mexico. His health is much improved.

**Dr. Samuel W. Kelley** was elected chairman of the section on Diseases of Children at the American Medical Association.

**Dr. Archibald C. Nash**, formerly of Ogdensburg, N. Y., a graduate from McGill University '99, has recently located at 747 Hough Avenue.

**Dr. Frank W. Hickin**, C. C. P. and S., '97, has removed from 66 Merchant avenue to 350 Jennings avenue, the office recently vacated by Dr. Cotton.

**Dr. Samuel G. Gant**, recently elected Professor of Rectal and Anal Surgery in the Post Graduate Medical School and Hospital, has removed from Kansas City, Mo., to No. 58 West 56th St., New York city.



**Dr. Clyde E. Cotton** has left Cleveland and moved to Black Mountain, North Carolina, where he has decided to live in future. The change was made on account of his health.

**Dr. Robert Pollock** was married on 6th June to Miss Benfield. On their return from their wedding trip to the Thousand Islands and down the St. Lawrence they will reside at 558 Hough avenue, a new home recently purchased by the doctor.

**Dr. A. R. Baker** has been elected president of the American Medical College Association. The association is composed of all the medical colleges of good standing in the United States, and aims to raise the standard of instructions and examination of students.

**Dr. Robert G. Schnee** left on the 10th of June to spend two weeks in Washington, D. C., combining business with pleasure. On his return he went immediately to Gallipolis, O., to spend several weeks with Dr. Albert P. Ohlmacher on bacteriological and pathological work. The doctor takes advantage of his vacation from teaching to pursue investigation in his chosen branch of the profession.

**Lead Poisoning.** M. Lavrand, according to the *English Druggist*, found that the administration of pills of iodide of iron, either alone or with phosphide of zinc, is an efficient remedy to prevent or arrest lead poisoning in those who work in white lead. The author found that although his patients continued to work in positions where they were likely to suffer, they improved in general health. The peculiar earthy complexion and anæmia characteristic of saturnism disappear under their use, and the amount of hæmoglobin is increased.—*Medical Brief*.

**Dressing Burns with Silver Leaf.** A trial is being made at Bellevue Hospital of a novel method of dressing burns, first introduced at the Johns Hopkins Hospital. It consists in covering the burned surface with silver leaf, using no adhesive material. As far as it has been used in Bellevue, it has given satisfaction. As it only adheres to the unbroken skin, it affords a good protective dressing which can be renewed without causing pain. This freedom from pain and shock constitutes its chief value as a dressing for burns. It is also being used at present in the new Albany Hospital for dressing the wounds in cases of abdominal surgery. The silver leaf is held in place merely by a retaining gauze bandage.—*Sajow's Cyclo*.

**Treatment of Tinnitus.** After giving an anatomical description of the ear, with illustration, and going over the various affections of the organs itself, and of other organs capable of causing the symptom of buzzing, the various remedies employed are passed in review. *Cimicifuga racemosa* has been recommended by Robin and Mendel as a drug governing vascularity and a moderator of reflex irritation. It is used as a tincture (15-40 drops), fluid extract (10-30 drops), or cimicifugin (product of precipitation of the tincture by water:  $\frac{3}{4}$ -3 grains). These authors have found, with the exception of cases lasting over two years, that cimicifuga gives prompt and complete results.—*Bulletin Generale de Therapeutique*.

**Longevity.** George Humphrey examined nearly 1000 persons as to the history of their lives, circumstances, habits, environment, etc. Of those persons seventy-four were centenarians. His conclusions in regard to longevity were: "1. That the primary factor in a long life consists in an inherited durability; the vital machinery is wound up to go for a given period, and but for accidents or in spite of them it will go till the time appointed. 2. That an important part of the primary inheritance is good digestive and nutritive power. 3. That temperance is necessary in use of the nutritive functions both in eating and drinking, and in regard to all kinds of food and drink. 4. That an energetic temperament and active habits conduce to longevity."—*Index-Lancet*.

**An Easy Method of Reducing Dislocations of Shoulder and Hip.** L. A. Stimson, New York, describes a method of reducing anterior dislocations of the shoulder, which has not failed in ten successive recent cases, and has never required more than six minutes to effect reduction. The principle is that of moderate traction upon the arm in abduction, and the procedure is as follows: A round hole about six inches in diameter is made in the middle of the canvas of a cot, about eighteen inches from one end. The patient is placed upon the cot, with the injured arm hanging down through the hole. The cot is raised upon blocks so that it is at a sufficient height from the floor, and a ten-pound sand-bag is fastened to the wrist of the dependant arm. After a wait of a few minutes reduction is found to have taken place. The procedure is not painful, and is an effectual, easy, expeditious and apparently safe method. Instead of a cot two tables might be used, placed end to end, the head resting on one, the body on the other, with the arm hanging down between them. In dorsal dis-

location of the hip the method is applied as follows: The patient is placed prone upon a table in such a way that his thighs extend beyond its end. The uninjured thigh is held horizontal by an assistant, to prevent tilting of the pelvis, and the injured one is allowed to hang vertically, while the surgeon, grasping the ankle, holds the leg horizontal (right-angle flexion at the knee), and gently moves it from side to side. If relaxation of the muscles is slow to appear, a sand-bag of five or ten pound weight is placed on the leg close behind the knee, or pressure is made there with the hand. This has succeeded in four-fifths of the cases, and often without the aid of anesthesia. In two cases in which it failed reduction was accomplished by traction in a line midway between right-angle flexion and full extension.—*New York Med. Record: Med. Review.*

**Medicine as a Profession.** Dr. John M. Dodson, in an address recently delivered before the Sunset Club of this city, said that in this country there is about one doctor to every 600 of population, while in foreign countries the ratio is about twice as high. The average salary of a physician in a large city is approximately \$2,000 a year, while in the country districts the average is about \$1,500 a year. To a young man studying the proposition of entering a profession, if he has merely the question of making money in mind, there are other walks of life which offer larger inducements. The highest possible return that he knows of in the profession is about \$80,000. There are two doctors in Chicago who make more than \$50,000 annually, 10 who make more than \$25,000, and 100 who make from \$10,00 to \$20,000 each year. The opportunities for original research and investigation are great. There has been a great advance in medical education, but there is much for the profession to learn, and one of the most important things is preventive medicine. He believes the time is near at hand when the physician will be paid by his client not alone for the curing of disease, but for its prevention.—*Medical News.*

**Cutting the Umbilical Cord.** The latest suggestion for cutting the umbilical cord and keeping it aseptic is due to the ingenuity of Professor Martin, of Greifswald, who advocates the use of curling-tongs heated to a white heat. He first ligatures the cord close to its attachment, and then burns it through, leaving a stump which is insusceptible to infection, and is safeguarded against accidental haemorrhage.



**Epistaxis.** Treatment—All that is necessary in epistaxis is to fashion with a pair of scissors a dry plug of prepared sponge, in size and length comparable with the little finger of a twelve-year-old boy. This should be carefully soaked in boiled water, to free it from grit, squeezed dry to free it from unnecessary fluid, and inserted its full length, gently along the floor of the bleeding nostril. No styptic is necessary. The expansive pressure of the soft sponge against the bleeding side, increased by the coagulation of a few drops of blood in its interstices, will check the bleeding at once. It should be removed in twelve hours; under no circumstances should it remain longer than twenty-four.—*Sajou's Cyclo.*

**Removal of Ear Wax.** Hardened wax in the external ear can often be removed readily by injections of warm water and soap, soda or ammonia. Many cases resist this, and require the softening effects of glycerin or sweet-oil for a day or two before syringing. Do not bother with these long processes, but use a half-strength solution of hydrogen dioxid in the ear for about five or ten minutes. This will disintegrate the hardest plugs, and they can be removed with very little syringing. I have yet to see the case in which this process has caused irritation or inflammation. Do not use too much force with the syringe. Wipe the ear perfectly dry with absorbent cotton and apply petrolatum. Wear a small plug of cotton in the ear for one day after removal.—*Phila. Med. Jour.*

**Teething.** Irritation from non-advancing teeth occurs because the normally flinty teeth, to which the soft gums can offer no practical resistance, are suffering from lack of nutrition. While the gum lancet gives temporary relief, yet it transforms normal into cicatricial tissue. In place thereof Dr. Wallen recommends correcting any faulty conditions in the infants' alimentary tract and placing upon a mixture of the calcic salts, approximating the proportions as nearly as possible to those found in the teeth. For example:

R Calcium phosphate, 2 parts.

Calcium carbonate, 3 parts.

Sodium phosphate, 1 part.

M. Triturate to an impalpable powder.

Sig.: Three to 4 grains or more, with other food, three or four times a day for a week; then once a day, *pro re nata*.

In anæmic children a trace of ferric phosphate is added.—*Richmond Journal of Practice.*

## Counter-Irritants.

## Teaching Etiquette.

"Madam," he began as the door opened, "I am selling a new book on 'Etiquette and Deportment.'"

"Oh, you are," she responded. "Go down there and clean the mud off your feet!"

"Yes'm. As I was saying, ma'am, I am sel"—

"Take off your hat. Never address a strange lady at her door without removing your hat."

"Yes'm. Now, then, as I was saying"—

"Take your hands out of your pockets. No gentleman ever carries his hands there."

"Yes'm. Now, ma'am, this work on Eti"—

"Throw away your pipe. If a gentleman uses tobacco, he is careful not to disgust others by the habit."

"Yes'm. Now, ma'am, in calling your attention to this valuable"—

"Wait. Put that dirty handkerchief out of sight and use less grease on your hair in the future. Now you look a bit decent. You have a book on 'Etiquette and Deportment.' Very well. I don't want it. I am only the servant girl. Go up the steps to the front door and talk with the lady of the house. She called me a downright, outright, no-doubt-about-it idiot this morning, and I think the book you're selling is just what she requires."

*Mrs. O'Harrity:* "Now put in another quart."

*Grocer* (putting in second quart): "Why didn't you ask for a half-gallon at first, and have done with it?"

*Mrs. O'Harrity:* "Och, bless yez sowl! One quart is for meself, and t'other is fer Mrs. Casey."

*Kathi* (in the museum, viewing the Venus de Milo): "Sepp, see here: somebody has knocked both arms off this woman."

*Sepp:* "Come, let's get out, or they'll think we done it."—*Fliegende Blaetter.*

*Bridget:* "Soy, Pat, fer why is it they calls this our tin weddin'?"

*Patrick:* "Faith, an' it's becaze we've been married tin years."—*Arkansas Traveller.*

## His Gestures.

Probably the *Catholic Standard*, which prints this dialogue, did not intend that stiff and awkward elocutionists should take it as a helpful hint:

*Teacher*: Your recitation was extremely good, Johnny. The gestures were particularly natural. Where did you get them?"

*Johnny*: "Git what?"

*Teacher*: "The gestures."

*Johnny*: "I ain't got the gestooors. It's hives."

"What are the last teeth that come?" asked a teacher of her class in physiology. "False teeth, mum," replied a boy who had just waked up on the back seat.

*Mrs. Norris*: "Where have you been Robby? I told you not to stir till I got back."

*Robby*: "Well, I only went down to the doctor's to ask him whether I was well enough to go out yet"—*Brooklyn Life*.

"I went to Sunday-school yesterday," a little girl said to her aunt, "and the teacher asked me 'who made me.' So I just told her nobody made me. I wonder if she thought I was a paper doll!"

*Teacher*: "Tommy, what is meant by 'nutritious food?'"

*Tommy*: "Something to eat that ain't got no taste to it."—*Indianapolis Journal*.

According to the *New York World* the nose is put in the middle of the face because it is the scenter piece.

"Gang awa', man," said an old Scottish gentleman, whose son told him he was about to practice medicine in England, "gang awa' and avenge Flodden!"—*Youth's Companion*.

A brother in prayer-meeting in a neighboring town, the other night, prayed for the absent "who were prostrated on beds of sickness and sofas of wellness."—*Rutland Herald*.



# THE Cleveland Medical Gazette

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AUGUST, 1900.

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## Original Articles.

### THE SUBMERGENCE OF INDIVIDUAL JUDGMENT.\*

BY T. CLARKE MILLER, M. D., MASSILLON, O.

Your program is so rich and comprehensive, and furnishes so much that stimulates thought and invites discussion, that I feel justified in presenting a few thoughts somewhat aside from the general trend of the meeting.

Of late years the field of the general practitioner has been invaded from all sides. Within the memory of some of us the physician was expected to be able to cope with almost anything physically abnormal. His great field was the treatment of the more acute and imperative diseases which were always present and always demanding relief. He was also the embodiment of the best accessible qualifications in the numerous fields which the specialist has since invaded and is continually fortifying. The "family physician" was the physician and surgeon. He was the captain, the pilot, and the crew on all occasions when the physical or mental craft was beset by storms or threatening seas. Disease was then, perhaps, less complicated and elaborate than now, largely because, in every respect, the people lived simpler and more natural lives. It seems that every refinement and self-indulgence and accomplishment and vice that has been cast into the stream of human life has disturbed its placidity, changed its currents and rendered its navigation more uncertain and dangerous. Even the great improvements in methods and machinery, the admirable growth in intelligence, and the better observance of sanitary and hygienic law have added to the complexity of the problems that confront the physician.

\*President's address before the Ohio State Pediatric Society, Columbus, May 9, 1900.

The trend to specialism does not affect the physician alone. The all-around mechanic or machinist is in worse plight than the "physician and surgeon" can ever be. An architect plans the most ordinary house. A dozen mills work out the materials, and the man who used to be a carpenter and joiner, simply sets it up. The machinist who could construct a machine from the approximately raw material has become extinct. His successor has acquired an admirable skill in making a peculiarly shaped hole with a remarkably intelligent power-driven tool, or cutting down an iron or steel beam on a machine so ingeniously constructed as to make the minimum demand on the atrophied muscles and brain of the operator. The machinist has become the least interesting and admirable feature of the machine. Even the old-time farmer who raised, practically, everything he needed for his family, has turned up as a wool grower or a stock raiser, or he makes a specialty of corn, or wheat, or tobacco, or what not.

I suppose that the treatment of children can hardly become a full-fledged specialty. And I take it that this society is not aiming at such an end, but that our object is rather to protect this part of the practitioner's field from submergence. Very early in the growth of specialism the general practitioner became willing to concede that, on certain lines, he did not know so much as the specialist. The camel's nose, thus hospitably admitted, became the initial aggression which rather rapidly grew into a demand that it should also be conceded that the said general practitioner does not know, even that which his experience and observation have taught him, half so well as the most immature and unripe specialist. Is it not possible that there was something real about the old-fashioned "sense of touch" which we read about but to a great extent have lost, through our dependence on thermometers, charts and other mechanisms? Do you not suppose that our fathers could measure the "fighting chance" that any given patient might have, nearly as well as we can? Is it no longer possible to assemble, in one man, the elements necessary to every day diagnosis and treatment of every day diseases?

But I am taking up valuable time and wandering rather circuitously to my theme, "The submergence of individual judgment." I shall not attempt more than is necessary to a definition.

The attitude of the mind implied by the word "judgment" presupposes information, mental training and experience. Much of medical knowledge is accepted on authority. Certain rules of conduct and practice are so well settled that we are under obliga-

tions to keep within those lines. We are not able, and we are not permitted, to bring all questions to a settlement at the bar of individual judgment. We ought not to be reluctant to rally around our banner when it is planted in knowledge and experience. On the other hand we ought not to hurry to enfile ourselves under every rag of assumed authority that enthusiasts or pushers of trade may raise. Discoveries should have the shop finish worn off before they are made the basis of laws that we are bound to respect. Neither the consensus nor the individual judgment ought to be submerged by an array of shrewdly manipulated figures or the acute enthusiasm of a few men. The knowledge and experience of the past ought not to be discarded in favor of the mere promise of the future. Yet we must not be too slow in submitting ourselves to the dominance of new, established truth. The triumphs of vaccination furnish a good illustration of the submergence of an antagonistic consensus. It won its way to honorable success and general acceptance against all opposition. Now, whatever judgment or opinion I may have constructed that is antagonistic to this experience and to these facts must be submerged. The question is no longer open to argument. The wisdom and necessity of vaccination must be conceded even though I may recoil from the seeming brutality of the measure, or may have been able to maintain an attitude of skepticism. As a physician, entitled to good repute, I am not at liberty to oppose vaccination nor to refuse it to my patrons. Yet the one time preference of the profession for humanized lymph was rather rudely submerged by the horrible possibilities urged upon the people by a few sensational doctors, abetted by the greed of trade. This, too, when the methods of production of animal lymph were extremely crude and the supply of even the impure animal lymph was too small to meet a limited demand. In this unfair battle the people's confidence in vaccination was so staggered that it has not yet recovered, and the loud-mouthed "antis" were furnished with arguments and horrors which they continue to use to the great injury of the public. We are easily enough dominated by the new, for we always want something better than we have. But the modern method seems to be to magnify the failures and tragedies of the past and exaggerate the successes and triumphs of the new idea in a popular, rather than in a professional way, until our patron is ready to demand that we do our work in a certain way or give place to someone who will.



The chemist has sometimes undertaken to dominate medical thought, but people—inside—are something more than laboratories and chemical reactions are not always uniform and according to pre-arrangement in the human organism. The chemist is a worshipful authority and no price can be put on his facts, but his speculations are not more than respectable.

There may be some abnormal conditions of body or mind which are not chargeable to germs. If so, the bacteriologist will never entirely and permanently dominate professional judgment, though he will be conceded all the importance to which he shall prove himself entitled. The experience of the profession has, I think, established serum therapy on a substantial basis. The antitoxine of diphtheria, whether correctly named or not, is a "positive advance in medical science" and practice, yet what strenuous and ingenious efforts have been made to quickly and completely submerge all conservative or antagonistic sentiment. By reason of the enthusiasm and unprofessional vaporings of a few physicians and the urgent greed of manufacturers and dealers it has come about that the night soil man is qualified to sit in judgment on your therapeutic measures in a case of diphtheria and in some fairly well civilized communities a board of health, or some other public authority, will undertake to contradict or approve your diagnosis, dictate your therapeutics and even treat your case for you, while at the same time the responsibility remains on your shoulders. Though scarcely any other disease is more easily and certainly recognized, you are told that a diagnosis that omits a bacteriological examination is scarcely a respectable guess. If you allow your judgment to be warped in this way, you, at once, begin to distrust your knowledge and experience. Your confidence forsakes you, your judgment goes with it, and that which was only an impudent suggestion becomes a humiliating truth.

If the Klebs-Loeffler bacillus may be present in a healthy throat, why may it not be present in a diseased throat which is not diphtheritic? If so, it seems to me that the moribund bed-side-diagnosis must be resuscitated. I am not at all sure that the time has fully come when the individual judgment and the evidence of the educated senses ought to be submerged. I am not quite ready to deny that the physician ought to determine, in the light of all present conditions, whether antitoxine ought or need not be used in a given case of diphtheria. Possibly a consensus has not yet

been reached, in spite of urgent and imperative dicta. Of course, as soon as a professional consensus has been fully formed, we will perform our little mechanical and brutal office as tamely as we now do in vaccination.

Is it not possible to be too ready to succumb to an array of statistics? It seems, sometimes, as though figures do mysteriously juggle themselves. The ingenious anti-toxine statistician will expunge a class of cases because they were "seen too late," "they were practically hopeless when the serum was administered," or they were so "evidently hopeless" that the shrewd maker of statistics "declined to use the potent remedy at all." If any one of you should be permitted to give your old-fashioned methods the benefit of this kind of expurgation, no doubt you could present some very pleasing figures.

We are told that the results become progressively poorer from day to day after the inception of this disease. This is no doubt true, for we know that a large percentage of the cases are well on the way to recovery in three or four days, under older methods of treatment, if the cases are taken in hand near the beginning of the disease. One way or the other diphtheria gets in its work in quite a short time. As a basis of comparison, the mortality previous to the days of the serum treatment is placed at about 50 per cent. of the cases treated. I incline to doubt whether the average experience of those present would justify us in saying that the mortality was half as high as that, what could have been the basis of this estimate of a 50 per cent. mortality? At the same time we are told that nearly 50 per cent. of the clinically diagnosed cases are bacteriologically spurious. Any considerable array of statistics bearing on the pre-anti-toxine period must have been largely collected in the pre-bacteriological era, hence the aggregates ought to be cut in two, for we would expect to find the percentage of spurious cases about the same as now, and the supposed spurious cases are claimed to be rarely if ever fatal. Consequently if the normal mortality was 50 per cent. of the cases or thereabouts, the genuine diphtheritic cases, practically, all died. However, it may not be the truth to say that Klebs-Loeffler diphtheria is the only diphtheroid disease attended by danger of fatal issue, and I am in doubt whether 50 per cent. of genuine Klebs-Loeffler cases will die in the absence of any treatment whatever.

It seems probable that some of our sanitary authorities overreach themselves when they refuse to take any precautionary account of diphtheroid diseases characterized by the presence of

other germs than the Klebs-Loeffler, or when the microscope fails to demonstrate the presence of the germ of Klebs, on the ground that the disease is "not infectious," or is "only feebly infectious." If not infectious, how does the individual contract the disease? If we are called upon to concede that the microscope is the only reliable and practically sufficient test, it becomes a very serious fact that a vast majority of physicians cannot have a bacteriologist at their elbows. Are they bound, then, to forget, ignore or discredit all their experience in the diagnosis and treatment of these grave troubles?

The value of diphtheria anti-toxine has been established by sufficient evidence and a superabundance of testimony, and its freedom from serious dangers is perhaps as fully confirmed, and yet, I feel that you may still be allowed the exercise, to some extent, of your individual judgment as to whether in a given case its use is necessary or not. There is, I think, considerable evidence that the use of diphtheria anti-toxine confers a measure of short-lived immunity in persons who have been exposed to diphtheria infection, so that its use for this purpose seems to be justified. I would like to be allowed, however, to claim that such use has not yet become absolutely compulsory.

A few months ago a very eminent American physician claimed as the result of "actual experience" "that immunity, after exposure, may be conferred for at least ten days, by a small dose of serum, provided it is given twenty-four hours previous to actual infection." He goes on to say that "A physician who fails to promptly immunize the members of a family in which diphtheria breaks out neglects to do his duty by those whose safety lies in his hands." This unprofessional pronouncement was reproduced in a good many medical journals all over the country, and probably contributed to the damnation of a good many physicians who were fully as worthy of respect as the dictator himself. I believe that that physician had a right to think what he said, provided the evidence was conclusive, as he saw it. I am not sure that he had a right to sow such a pronouncement broadcast. If he had, then none of us has a right to think differently or at least to act otherwise than he directs. He has foreordained our condemnation if we do.

We are so beset by new names and new pathologies that we are in danger of coming to distrust or forget all that we had considered established and reliable. We are buried in an avalanche of new drug combinations and inventions, each adapted to almost



all diseased conditions, or at least intallible in some until we are liable to distrust all therapeutic measures.

The bactericidal furor seems likely to overwhelm our confidence in even unsterilized sunlight. All of nature's life sustaining products seem to be charged with dangers before they have passed the portals of nature's laboratory. On the most contemptible evidence we are officially assured that a quart of milk is likely to infect a large family with a terrible and almost hopeless disease.

Unless we keep our cool judgment in hand we will soon, as a profession, be in that confused mental state suggested by the pregnant though inelegant question, "Where are we at?"

Jugglery and sleight-of-hand performances, of course, interest and mystify us, but we can afford to cherish a moderate degree of skepticism on the question of the applicability of such accomplishments to useful purposes.

The apostle to the Gentiles cautioned his hearers, "not to be carried about with every wind of doctrine," etc.

When conservatism becomes singular, of course, it should receive another name.

We should keep ourselves informed; keep our faculties in training, and, under ordinary circumstances, refuse to distrust our own judgment. Yet, when the profession has found, and given voice to a consensus, we must hear and obey.

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## APPENDICECTOMY IN THE QUIESCENT PERIOD.\*

BY WILLIAM E. LOWER, M. D., CLEVELAND, O.

Assistant Surgeon to St. Alexis, Surgeon to Lutheran Hospital.

I hope the title of this paper will not be misleading and convey to you the impression that the writer would defer operations in the acute stage of appendicitis and wait for the interval. On the contrary, I am a firm believer in the early operation for appendicitis, as soon as the diagnosis is made, providing the environments are favorable. The acute cases in which the initial symptoms are mild—in the hands of competent medical men—where observations and the progress of the case can be noted every few hours, it may be safe to wait. But from the very treacherous and uncertain nature of the disease, the cases in which waiting would be advised must be very rare.

That a large number of cases of appendicitis do get well if left to nature or treated medicinally no one will deny. That a

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greater number recover if treated surgically has been proven beyond a doubt. It is that class of cases in which the patient has passed through one or more attacks without surgical intervention that I desire to call attention.

With the improved technique and the modern aseptic methods of surgery, the mortality rate in appendicectomy in skilled hands has been reduced to less than one per cent., that is to say, ninety-nine cases out of every hundred operated upon in the interval will get well. "It is difficult or impossible to predict after one mild attack of appendicitis whether no recurrence, a recurrence in a mild form, or a recurrence of a severer and dangerous type will ensue. One is forced to regard the future of every individual who has had a clearly defined attack of appendicitis, no matter how mild, as uncertain. The difficulty in deciding arises in those cases which have passed through a mild attack. There can be no doubt as to the course to pursue when there have been several attacks. One must contrast the danger connected with the operation with the danger associated in allowing the disease to recur. The last danger is a real one." It is safe to assume that out of one hundred cases that have had one attack, there will be a recurrence in at least 25 per cent. I believe statistics show about 50 per cent. of recurrence after first attack, the liability to a recurrence after a second or third attack is much increased. If we had some way of knowing the nature of a recurrence we might anticipate it and decide accordingly, but no one pretends to foretell the disaster a second or third attack may bring, whether a ruptured or gangrenous appendix with its concomitant dangers demanding the most radical or immediate surgical intervention, or whether a ruptured appendix, discharging its pus into the general peritoneal cavity, known as the fulminating variety, producing a fatal peritonitis. Again, the uncertainty as to time and place when an attack may begin must be considered. The disease most invariably manifests itself with a sudden onset. Without warning an attack may begin when the patient is out of reach of proper aid. These are not the only complications liable to occur in postponed cases, although most important as to life. Other conditions of a serious nature are the complications and sequelæ that arise when pus has formed and drainage must be instituted. First among these may be mentioned ventral hernia. When the muscles are divided and drainage continued for any length of time, the danger of a hernia is great, requiring a second operation for the hernia. Secondly, the

danger of a fæcal fistula—a not infrequent complication when the cæcum cannot be properly closed and where drainage must be practiced. Thirdly, the length of time necessary to recover from a drainage case.

Another condition, though of minor importance, yet of sufficient significance to demand attention, is the mental discomfort caused by a knowledge of the fact that a recurrence may ensue at any time and place. In many cases the fear of bringing on a second attack prevents the customary amount of physical exercise, causes annoying discretions in diet, and in short, deprives them of many pleasant and necessary diversions.

It is in this class of cases that there will be found upon deep pressure in the right iliac fossa a point of "soreness" which is of considerable importance, for it indicates a lame appendix—one in which complete recovery has not taken place, and one which only needs a slight provocation to renew an attack.

The question of time is often considered. You can reply to this with a considerable degree of certainty that at the end of three weeks they will be able to return to work.

My personal experience in cases operated upon in the quiescent period shows an average of from ten days to two weeks in the hospital. Many cases can leave the hospital in ten days, and at the expiration of three weeks return to their vocation.

The laity are becoming educated on the question of appendicitis, and many insist upon immediate operation, and more would be operated upon could they get the consent and approval of their attending physician. The cause of deferred operations is often due to the family physician. If a case has passed through an attack of appendicitis without operation the attending physician should not only recommend but should insist upon an operation in the quiescent period.

We have passed the experimental state in dealing with appendicitis—we are dealing with facts.

The technique employed in opening the abdomen is the grid-iron method through muscles and fascia, with the smallest skin incision, without any given dimension, consistent with a complete operation.

In summarizing, I would say, first, all cases of appendicitis should be operated upon as soon as the diagnosis is made if the surroundings are favorable. Second, if a patient has passed through one attack, a second should not be allowed to occur, but



an operation in the quiescent period should be performed. Third, an operation at this time ensures:

- a. The least danger to life.
- b. The shortest period of disability.
- c. The smallest danger of complication.

*The Osborn.*

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## CONVULSIONS IN CHILDREN.\*

BY WM. A. DICKEY, A. M., M. D., TOLEDO, O.

Professor of the Principles and Practice of Medicine and Clinical  
Medicine, Toledo Medical College; Attending Physician  
St. Vincent's Hospital; Member American  
Medical Association, &c.

A convulsion is a symptom, not a disease. Often being in the dark as to the exact cause, we are per force compelled to speak of it as if it were a pathological entity. It occurs at a time of rapid development in the child both of the muscular and nervous system; when there is that lack of co-ordination which comes in later years. Their embryonic condition makes them easily disturbed by chemic or other agents generated within the alimentary canal or taken into the body by means of the respiratory system or otherwise.

There is often an inherited tendency to convulsions; an unstable nervous system. The children of parents who have been epileptics, chronic syphilitics, or whose constitutions have been undermined by the prolonged and excessive use of alcoholic beverages and whose hygienic surroundings through generations have been bad, are certainly prone to transmit to their unfortunate offsprings all manner of neuropathic tendencies. It is unfortunate but true, that this class of people marry and inter-marry almost indefinitely, leaving to the state as a legacy, nothing but a progeny mentally weak and infirm. The causes of eclampsia infantilis are "too numerous to mention." For the sake of simplicity of arrangement they may be divided into two general classes, *predisposing* and *exciting*. To the predisposing causes belong the class I have just mentioned and need, possibly, neither further nor more extended notice.

Of the exciting causes, I want to speak first of the so-called reflex ones, many of which are not reflex at all, but are direct. Others have no influence whatever. One of the most prominent

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of these, so much so as to be mentioned in all text-books, is dentition. Now, I am just skeptic enough to believe that the evolution of a tooth, *per se*, never produced a convulsion. This physiological process occurs at a time when the child is stuffed like a fowl with all manner of indigestible food, which the undeveloped stomach is unable to digest; it undergoes fermentation, poisonous products are formed and absorbed accompanied by high fever and a convulsion follows. In an experience of more than twenty years and fair powers of observation I must confess I have never seen a single case where I thought "teething" produced a convulsion. Others, however, seem to think differently and proceed to lance the gum. To my mind this is a procedure barren of good results. Unless the tooth comes through immediately cicatricial tissue of greater or less density is formed and "the last condition is worse than the first."

Stomachic and intestine indigestion and overloaded colons are sometimes placed in this category also. These are direct rather than reflex and constitute one of the chief causes of the trouble. As a result of the conditions alluded to we have the absorption from the alimentary canal of ptomaines, which, circulating through the brain and nerve centers are followed by high fever and convulsions. It is claimed by some very careful observers that we have a "convulsion center" and a "heat center." They are closely and intimately connected.

A disturbed thermogenesis from auto-infection acting on the former produces the eclamptic seizure. This auto-infection, the eruptive fevers excepted, stands at the head of the lists as the most potent factor in the production of infantile convulsions. Adherent prepuce is I think often a source of this trouble and when others have been eliminated the gland should be carefully examined. While the presence of intestinal parasites must be acknowledged as a cause, still I am satisfied it is only a contributing one and not of major importance, the prime cause being the auto-intoxication already referred to.

In the acute infective diseases of children a convulsion not infrequently takes the place of the rigor in adult life. Scarlet fever, less frequently measles, is nearly always ushered in with a convulsion, and is to be thought of and careful search made for the eruption or inquiry made as to whether the child has had the disease in question. Diphtheria and pneumonia must also be placed "on the list," more particularly if accompanied by hyperpyrexia, which is an important element and one not to be ignored.

These causes, so often classed among the reflex are not of this kind, but are direct, caused by the specific poison, the toxicity, circulating through the blood and nerve centers as well as the consequent fever. The bacillus of influenza is also a frequent cause either by its own toxicity direct or the fever it produces.

The influence of rickets in the production of eclampsia is not to be lost sight of, and yet many cases attributed to this can, upon careful examination be found to be due to other causes. Brain tumors, meningeal hemorrhages, hydrocephalus and the like are all at times the cause of the trouble.

Eclampsia Infantile in children are always to be looked upon as a matter of serious import. At this age the brain and nerve cells are easily affected, and if the eclamptic seizure is not soon stopped, many times are seriously impaired, as the writer can testify from personal observation. Hence the importance of early and well directed treatment. According to Gowers seven per cent. of chronic epileptics had convulsions in infancy.

Having gone over the most important factors that enter into the production of this distressing symptom we now come to the very important and practical one of its treatment. It is useless to say to an audience like this, that the first and most vital thing to be done is the removal of the cause when it can be found; though I grant this is easier said than done. Dr. J. Lewis Smith, who has done so much that reflects credit alike to himself and American medicine, says in his work on "Diseases of Children:" Inasmuch as the physician is often required to treat eclampsia in ignorance of the cause, the same measures are demanded, to a considerable extent, in all cases. As early as possible in the attack the feet should be placed in hot water, to which mustard is added, or if it can be produced with little delay, a general warm bath may be used in place. Osler, in his classical work on "Practice," approves of this procedure by saying: The practice is almost universal of putting the child in a warm bath, and if there is fever, the head may be douched with cold water.

Tyson directs that "If it (the cause) be undigested food, an emetic and an enema are indicated; if dentition is at fault, the lancet should be promptly applied to the gums. The next step is the immersion in a warm bath, say 95 degrees F., increased to 100 degrees F., to which mustard may be added." Lockwood says: "No time should be lost in immersing the child in a bath at 95 degrees F.; baths of a higher temperature are not suitable." And so I can go



on almost indefinitely. So universal has this become among the laity, fostered and kept up by long and continued advice by the profession, that a child is no sooner seized with a convulsion than a tub is brought forth, filled with hot water into which a handful of powdered mustard is poured and the nude child is placed in it. The length of time the child is allowed to remain in the bath will depend entirely on the peculiar and popular notion of those directly interested, as well as the trend of thought of the attending physician. In the vast majority of cases, it does seem to me this is not only illogical, but unscientific. I will not tax your patience with the condition in which a little sufferer in convulsions is found; you are all as familiar with it as I am. There is one, however, to which I want to call especial attention, and that is the fever. This will usually be found to be from 103 degrees to 106 degrees F., with all its accompanying manifestations. **In what other condition than a convulsion, with a patient's temperature as I have indicated, would it be put in a hot bath?** not a single one. Why, then, is it done in convulsions; what purpose does it serve; in what way does it benefit the patient? For the past six or eight years it has been my custom to instruct those who have, from time to time, honored me with their presence in the class room, as well as to carry out in private practice, the following plan, which I can assure you I have had no occasion thus far to regret. When called to these cases to first use a thermometer, no matter how urgent the symptoms. While the physician is waiting for the instrument to register, a history of his patient can be gleaned. Some knowledge, if not already known, of its ancestry can be elicited. Has it now or has it had scarlet fever, measles, diphtheria, whooping cough or pneumonia? If old enough to take solid food, what has it been eating for the past twenty-four hours? With this survey of the case, and if a patient will die before this can be done, it will die no matter what you may do. He is ready to read his thermometer, and if it indicates a temperature of 103 degrees or more and the extremities not cool, I do not hesitate to say if you will pardon the apparent dogmatism that a hot bath is never indicated. I believe it to be an element of harm rather than good.

On the contrary, a cool or cold sponge bath or pack is to be used. The child is to be stripped, and the entire body is sponged with cool or cold water in the most methodical way. If the temperature be higher than the point indicated and the symptoms urgent, with the boldness that comes with confidence and exper-

ience the sponge bath in the manner indicated can be discarded and the entire body wrapped in a sheet previously wrung from cold water. Or the child can be put in a bath tub filled with water at a temperature ranging from 80 degrees F. to 95 degrees F., brisk friction being kept up meanwhile. The injection of cold water into the rectum will also be beneficial. A recital of cases in which any special line of treatment has been used are usually uninteresting and tedious, or they could be given without number in proof of the efficiency of this manner of dealing with these cases. I am pleased to note that Dr. Anders, in his recent very superior work on the "Practice of Medicine," speaks in the most complimentary terms of this procedure. Do not mistake my meaning, and infer that I think all cases of convulsions are to be treated in this way. Meningeal hemorrhages, cerebral tumors, adherent prepuce and the like will not, of course, fall in this category. But these are not the ones we are commonly meeting.

During the paroxysm inhalations of chloroform can be used, but its administration should never be intrusted to one ignorant of its effects. If it is thought to be due to undigested food, the stomach tube or an emetic will be of service and should be used. An enema of warm soap suds will often bring away a mass of offensive material. To a child one year old two grains of hydrate of chloral, in conjunction with five of sodium bromide, by the mouth, or twice the amount by the rectum, will be good treatment. Morphine, hypodermically in one-thirtieth grain doses may be given safely, and repeated in an hour or two, if found necessary. There are cases in which some one of the coal-tar preparations will be of unquestioned value, but they must be used with circumspection, and not at all after the fever has subsided, on account of their great depressing effect. A cathartic, preferably the mild chloride of mercury, will always be beneficial and should be administered.

In conclusion, my plea is for the cold bath rather than for the time honored hot one. Under its influence not only is bodily heat dissipated, but inspiration, which is short and shallow, becomes much longer and deeper. As a result more oxygen is taken into the blood, and the carbonic acid, which has been collecting, is liberated. The blood in this way becomes purer, and the brain cells and nerve centers are in consequence supplied with a more healthy fluid, and thus enabled to perform their function in a more perfect manner. The heart, which has been rapid and irregular, and many times exceedingly weak, is given tonus, and

forces the blood in even currents to all parts of the body. The kidneys secrete an increased amount of urine, and from all avenues of the body poisonous products, which had been circulating through brain, nerve and muscle, and are an important element in producing the eclampsia, are in this way liberated and gotten rid of.

I am aware that even in a progressive age like the present, methods of procedure sanctioned by high authority and hoary with age, are not easily changed. More particularly is this true of those affections with which we seem to be familiar by frequent contact. It is well, however, for us at times to cast about us, take new bearings, as it were, and see if from this vantage ground some step forward cannot be taken.

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## THE USE OF RUBBER GLOVES AND GAUNTLETS AS A MEANS OF PREVENTING INFECTION IN SURGERY.

BY HUNTER ROBB, M. D.

Professor of Gynæcology, Western Reserve University; Gynæcologist-in-Chief to Lakeside Hospital, Cleveland, Ohio.

Everyone will concede that it is practically impossible to render the skin absolutely sterile, since the deeper layers will always harbor organisms which may prove virulent. Nevertheless, after carrying out the usual methods for sterilizing the hands and forearms we can with certainty prevent them from carrying infection into our wounds if both the operator and his assistants always wear rubber gloves and sleeves, since these can readily be rendered absolutely aseptic. I have been using rubber gloves as a routine only for the past five years, although prior to this time I had employed them more or less for a period of two years. Only in the last year or so have I learned to fully appreciate the advantages offered by the rubber sleeves. The gloves and the sleeves can be easily sterilized by boiling them in a 1 per cent. soda solution. Since using the gloves and sleeves as a routine we have had during the past year 114 consecutive unselected abdominal sections without a death, in 29 of which pus (from one ounce to several litres) was found at the time of operation. The pus was removed as thoroughly as possible by irrigating the abdominal cavity with sterile salt solution and then sponging it dry. Drainage was used only in one instance. Suppuration of the abdominal wound occurred in eight cases (7.2 per cent.);



in four cases it was slight and entirely confined to the skin. In two of these cases the staphylococcus pyogenes aureus was demonstrated. In four cases there was a considerable amount of purulent discharge in the lower angle of the wound, which did not, however, involve the deeper tissues. In these cases the staphylococcus pyogenes aureus was found in the pus. In a certain number of our cases we were using at that time chromicized catgut, and to this we attribute the suppuration, which appeared from ten days to three weeks after the operation. These sutures were never absorbed but gradually worked their way to the surface and were discharged from the wound. In some instances, however, only about a drop or two of pus would be present as a result of this shedding of the suture. Since June, 1899, we have resorted again to the use of sterilized silver wire and have used this material entirely for the fascia and muscular sutures. Since this time we have had pus only in one wound, and in this case we were forced to conclude that the infection had occurred secondarily as the result of the localized suppurative process in the pelvis about the former site of the large pelvic abscess. I attribute our favorable results very largely to our aseptic precautions. As I have pointed out, the choice of a suitable and properly prepared suture material is of the highest importance; nevertheless, I cannot but think that among the important factors in obtaining an aseptic condition are the rubber gloves and armlets.

The gloves and armlets are made by The Miller Rubber Mfg. Co. of Akron, O.

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## LETTERS FROM PARIS.

BY H. E. HANDERSON, M. D., CLEVELAND, O.

The gossiping diary of Mr. Samuel Pepys and the more dignified journal of John Evelyn are, doubtless, familiar to most readers. Possibly, too, the Paston Letters of the latter half of the 15th century have attracted their attention. Such homely personal and domestic records impress upon most minds the facts of history with a definiteness and minuteness of detail rarely supplied by the pen of the professed historian. Like photographs, the limitations of their field are more than counterbalanced by their truthfulness to nature and their accuracy of definition.

These thoughts have been suggested by the recent perusal of a collection of letters\* from the pen of an eminent doctor of

\*Lettres choisies de feu M. Guy Patin, Docteur en Medecine, de la Faculte de Paris, and Professeur au College Royal. Rotterdam, 1725. 5 vols., 12 mo.

Paris about the middle of the 17th century. Covering the period from 1645 to 1672, they introduce us behind the scenes of the great political drama enacted upon the stage of Paris in the 17th century, in which the principal actors were Louis XIV, Mazarin, Anne of Austria, Conde, Turenne, Vauban, Moliere, Fenelon, Bossuet and a host of others whose names are prominent in history. Written by a physician to other physicians, these letters are peculiarly rich in the medical gossip of the period, and furnish an insight into the medical ideas and practice of the physicians of Paris not easily obtained from other sources.

Their author was Dr. Guy Patin, a pupil and protege of the younger Riolan, and for many years a prominent figure in the famous Faculty of Paris. Born in 1601, Patin graduated in the University of Paris in 1627 and advanced through the grades of censor (1642) and professor of surgery (1646) in that institution, to the office of Dean of the Faculty in 1650-52. In 1655 Patin succeeded the younger Riolan as professor of medicine in the College Royal, a position which he continued to hold until his death in 1672. Acute, ambitious and disputatious rather than profound, Patin was naturally a stout defender of dogmatic medicine and the traditions of the ancient Faculty, and a ready and trenchant pen made him prominent in the numerous controversies of the physicians with the apothecaries, the barbers and the representatives of the surgical College de St. Come, and a violent opponent of the heresies of Paracelsus, Van Helmont and the Chimists. His bitter hatred of Mazarin and the monastic orders and his manifest sympathy with the Frondeurs indicate an independence and patriotic instinct, which may, perhaps, do greater honor to his memory.

In the hope that the medical profession of the present day may feel some interest in the ideas and the career of their acute colleague of the 17th century, I venture to submit a few extracts from his entertaining and characteristic correspondence.

The "horseless carriage" seems to be the coming fad of the 20th century. It may, therefore, surprise some of us to read that it had also excited the ingenuity of inventors two hundred and fifty years ago. In the first of his letters, bearing date January 10, 1645, Patin writes:

"It is true, as you have been informed, that we have here in Paris an Englishman (son of a Frenchman) who has an idea of making carriages capable of traveling in one day from Paris to Fontainebleau and back without horses and by means of certain

wonderful springs. They say that this new machine is being constructed in the Temple. If the idea is a success it will prove a great saving of hay and oats, which are extremely scarce."

Fontainebleau is thirty-five miles from Paris, and a horseless carriage capable of traveling on ordinary roads seventy miles a day remains a desideratum even in this 19th century. A few lines later the writer's medical bias bursts forth as follows:

"I am under obligations to you for the book of M. Potier, which you have presented to me. However, I have grave doubts whether the public will thank M. Huguetan for publishing such works, which are better adapted to make charlatans than great doctors. This book is filled with bad remedies, boasting and falsehood, and I would to God that nothing of the sort had ever been printed. There are already too many Chimists and miserable empirics, and too few people who study and thoroughly understand the Epidemics of Hippocrates. I have heard M. Moreau (who, like Potier, is an Angevine) say that Potier was a great quack and an arrant knave, who took upon himself to intermeddle with our profession and mounted the stage of medicine only the better to dispose of the wares he had to sell; also that he had left the kingdom and gone to Italy. In his book too he poses as an Aristarchus and censor of physicians. To hear him talk one would think he was the only man of skill and learning in the world. What makes me thoroughly suspicious of him is that he speaks too often of his diaphoretic gold, his opium and his laudanum, and too frequently casts reflections upon the other remedies from which the public receives aid and comfort every day. His book is a constant censure of ordinary medicine. Fools only will admire it, and honest folk will reap no benefit from it. It will either become a subject of ridicule itself, or will render our profession ridiculous."

The book referred to in this extract was probably the works of Pierre de la Poterie, a native of Angers, and one of the later Paracelsists, who, in consequence of his fondness for the preparations of antimony, had been expelled from the Faculty of Paris in the year 1609.

Antimony, introduced into medicine by the alchemists of the 15th century (especially by the writings of the somewhat mythical Basil Valentin) became during the next two centuries the well known shibboleth of the Chimists in their controversy with the Galenists or "physicians of the old school." Its exploitation in France, chiefly through the influence of Du Chesne, ordinary physician of Henry IV, aroused to such a degree the wrath of the Faculty and especially of the disputatious Riolan senior, that even the great Pare thought it prudent to suppress his endorsement of its virtues, and in 1603 Turquet de Mayerne, through



the lack of similar discretion, was placed under the ban in the famous decree which exhorted "All physicians, in all places, to shun and banish Turquet himself and all similar monsters of humanity and heresies of doctrine, and to remain firm in their adherence to the teachings of Hippocrates and Galen." As late as 1643 the partisans of this new school were interdicted from practice in Paris, and it was not until 1666 that the proscription of the use of chemical remedies was formally removed by the Faculty.

What Patin thought of antimony may be inferred from the following passage in a letter of 1651:

"We have here sick a sad rogue of our profession, M. Elie Beda de Fougerais, but I don't think he will die. He often gives antimony, but never takes it himself. It seems as if God permitted charlatans to live longer than other people, to see if they will amend their ways. However, he might take unto himself this particular fellow in all confidence, without waiting for his conversion, for he is quite beyond all hope of amendment. I don't believe there is on earth a quack more determined or more perverted than this miserable Chimist, who is lame in both legs like Vulcan, and with his antimony slays more people than three good men can save with ordinary remedies. I believe if this fellow thought there was in the world a greater charlatan than himself, he would try to have him poisoned. He carries in his pocket white powder, red powder and yellow powder; cures all sorts of maladies and sticks his nose in everywhere. Those who do not know him admire him, others detest and make a laughing-stock of him."

Of the more famous Chimist, Theodore Turquet de Mayerne, who has been already mentioned and who attained the position of ordinary physician to both James I and Charles I of England, Patin, of course had no better opinion.

"But to return to M. de Mayerne, who is still living in England I believe, he is a physician of Montpellier who came to Paris in 1602, and, as he prided himself on being a great Chimist, he got into a quarrel with some of the Faculty. The result was that the Faculty decreed that none of its members should consult with him. This quarrel led to an apology from Mayerne, of which he was no more the author than you or I. It was the work of two of our members, Seguin our Ancient, who always had a weakness for charlatans, and his brother-in-law Akakia, who in 1605 died of the small-pox, contracted in Italy, whither he had gone with M. de Bethune, our ambassador to Rome. They acted in spite of some of our Ancients, who were men of probity and strove with good intentions to prevent the Chimists and quacks from acquiring credit here and selling their humbugs to the loungers of Paris. This Mayerne is still in England, very

old and almost in his second childhood. It is said that he has abandoned the King's party and taken sides with the Parliament. I saw one of his children (since dead in England) studying medicine in this city. It is said that Mayerne is very harsh with his children, and so avaricious that he lets them die of hunger. He is a great Chimist, extremely rich, and cunning enough to get many a Jacobus for a letter of consultation of five or six pages."

(TO BE CONTINUED.)

## Abstracts and Extracts.

### THE TREATMENT OF INGUINAL HERNIA BY INJECTION.

Regarding the cure of inguinal hernia by injection, much may be said for and against it. There is among the laity an old prejudice against being operated on for hernia, and a promise of cure by other means is readily accepted. While to-day we can say to those afflicted that we can cure more than 90 per cent. of inguinal herniæ by operating, yet this condition has not prevailed sufficiently long for the general public to be aware of this fact. They are being educated gradually in this direction, and it will not be many years before those suffering from hernia will seek a cure by operation, in preference to wearing an ever-torturing truss. There are those who desire some relief from the distressing condition, and if they cannot be induced to submit to an operation, then we can use in a large number of cases an injection which, if used properly in conjunction with a well fitting truss, will give in many cases great relief, if not a permanent cure. The fact must not be overlooked that a large percentage of those having inguinal hernia are working people, and the loss of three or four weeks' time is an important matter. By the injection method no time need be lost. You can treat the patient, and in an hour he can be at his work. Injections for this purpose are not new, but for those not acquainted with the method I will give a brief explanation. I use an injection differing somewhat from that employed by Heaton and his followers. Heaton's formula was fluid extract white oak bark, thickened by the addition of a small quantity of a solid extract of white oak bark, and to every twenty minims a half-grain of morphine was added. I use the following formula:

Fluid extract quercus alba.....	1½ ounces.
Solid extract quercus alba.....	1½ drachms.
Carbolic acid crystals.....	2 drachms.
Iodine resublimed .....	2 drachms.
Morphine sulphate .....	10 grains.

Mix the carbolic acid and iodine thoroughly in a mortar, add the other ingredients, and triturate thoroughly.

Twenty minims of the above is a maximum quantity for one injection. Before using an injection a truss that will retain the hernia perfectly must be fitted to the patient; without a perfectly fitting truss nothing can be accomplished, and the fluid should not be used. By a perfect fitting truss is meant a truss that will retain the hernia in any position the patient may assume. Having secured this, prepare the patient by cleaning the lower part of the abdomen thoroughly with soap, warm water, and brush. If there is much hair covering the inguinal canal it should be shaved. After having cleaned the abdomen thoroughly wash the parts over the inguinal canal with alcohol and ether. The syringe needle should be thoroughly clean and kept clean; in fact, every precaution should be taken to protect the patient from infection. The needle should be a stout one,  $1\frac{1}{2}$  to 2 inches long. Place the patient in a recumbent position. Having reduced the hernia, the index-finger is placed in the inguinal canal by invaginating the skin over the external ring and pushing the finger up the canal until the tip reaches the internal ring. By feeling over the site of the internal ring the tip of the finger in the canal can be felt, and the needle should be inserted at this point, directly over the finger-tip, and pushed down quickly until it passes the end of the finger. Three to five minims should then be injected slowly, and as the finger is withdrawn slowly the needle is made to follow it for about half an inch, during which time the fluid is still injected slowly, and when the twenty minims has been injected the needle should be withdrawn suddenly to avoid depositing any of the fluid in the subcutaneous tissue; if the latter occurs it causes intense burning for a short time. The truss should be placed in position immediately, and the patient should lie down for about half an hour. If there is much pain after the injection, the placing of a hot-water bag over the site of the injection will soon ease the pain. The injection should be repeated once a week for three or four weeks, when if the hernia does not come down after having taken the truss off, and having tested it by the patient coughing or stooping, you need give no more injections. The truss should be worn for at least four weeks longer, when if the patient desires it may be left off. In most cases it is well to advise a truss to be worn for from four to six months; one with a large soft pad is preferable. Many patients will not go without a truss



even though they know they can, as they feel more secure with a truss on.

During the last eight years I have treated by injection 148 cases, as follows: Adults, 104; children, 16; double hernia, 28.

Of the above number of cases of single hernia in adults sixty-five were under 50 years of age, and thirty-nine over 50 years of age. Under 50 years of age hernia occurred on the right side thirty times, and on the left side thirty-five times; over 50 years of age hernia occurred on the right side twenty-nine times, and on the left side ten times. Double inguinal hernia appeared twenty times under 50 years of age, and eight times over 50 years of age. The number cases of hernia in children under 10 years of age was sixteen, all on the right side. Of the total number treated by injection (148), none of the double herniæ were cured, but all were more or less benefited—that is, the inguinal canal was reduced in caliber by the new connective tissue that had been formed through the inflammation produced by the fluid injected, and in that way the herniæ were retained by the truss with more comfort to the patients. Of the 120 cases of single hernia—104 adults and 16 children—treated by injection, 50, or 48 per cent., were successful one year from date of last injection. Two years from date of last injection, of the above 58 cases 40 were traced; 32, or 26 per cent. of the whole were not wearing a truss. Eight had been wearing a truss for periods of a few months to a year. Of the remaining 18 I am uninformed. Of the 62 cases not cured, all were more or less benefited. Of the 16 children treated, who were included in the 58 reported cured, all proved a success. None of the children had more than two injections, and they did not exceed eight drops at one time. I wish to state that of the 58 cases reported cured at the end of one year from last injection, the major portion of them were of recent origin and were not difficult to retain with a truss, and were cases in which the canal had not undergone any very great change. On the other hand, all the cases in which I failed to effect a cure were in those that gave a history of several years' standing, and many of them experienced considerable difficulty in retaining the hernia with a truss.

In conclusion I would say that in regard to recent inguinal hernia that can be retained easily with a truss, we can say to those seeking relief that they can probably be cured by injection. To those who have hernia of long standing and retained with difficulty we cannot promise a cure. We can relieve them in many cases, but the greater number will be failures. On the other

hand, we can say to them that no matter of how long standing the hernia may be, we can today cure over 95 per cent. of them by an operation; and I would always encourage an operation in any case, notwithstanding the fact that I have cured many cases by injection and will probably continue treating suitable cases in that way, not from choice, but because of the fact that many people will not submit to an operation.—*Thomas P. Scully, M. D., in Medicine.*

GERMS AND MONEY.

I must say a word about the dangers of handling filthy lucre while doing office practice. Medical men need all the money that they get, and they are obliged to accept fees whenever they are offered to them. No matter how filthy the lucre may be, the doctor is obliged to take it in hand whenever he has the opportunity. In office practice especially it is dangerous to handle cash that is saturated with the germs of disease, and much of the current money is. The doctor himself might be willing to run the risk of infection, knowing, as most medical men do, that they must have money to live; but they must also know that they expose their patients when they take a dirty fee from one and immediately proceed to treat another surgical case.

I first had this subject called to my attention in a very forcible way during my earliest days in practice. A young man of the world came to me for treatment, and after removing certain very much soiled dressings, he presented for inspection all the pathological conditions that Venus could bestow on one subject. After applying a clean dressing—by the patient himself, and without washing his hands—he by careful manipulation counted out the filthy dollar bills of my fee. By good luck he placed the money upon a piece of paper on the table, from which it was removed and placed in a disinfectant solution for purification before putting it again into circulation.

This experience led me to realize that much of all money received from office patients was liable to be unclean and unfit to be handled. From that time I have held that all money was guilty of being septic until proved innocent. How to guard against soiling the hands with money is rather a difficult problem. I remember that the bookkeeper of the great surgeon, James R. Wood, collected all office fees, and so the doctor was preserved from danger in this regard. Others at the present day may conduct their business in the same way, but the vast majority are obliged to handle all moneys received. I tried washing my hands

after receiving money and making change, but found that that required too much time. Now I pick up my fees with a forceps, drop them in a money box, and at the close of the day put the receipts in a sterilizer and disinfect them at the time that I have my instruments made clean. This may appear to be over-particularity, but eternal vigilance is the price of cleanliness in surgery.—*Alex. J. Skan, Brooklyn.*

#### THE SPECIALIST.

Please permit me to say most emphatically that, in my opinion, no one should think of entering a specialty of any kind in medicine or surgery who has not been in general practice for five or ten years, preferably the latter. Again, the term specialist naturally implies authority, and certainly no one can be an authority on any subject surgical who has not given that subject long and careful study, and has had abundant opportunity to profit by clinical instruction.

The bane of specialism today is the "blooming out" of a class of men to practice specialties, who have no practical knowledge of the same. Such action should receive the strongest censure from the entire profession. What right have these men to claim a knowledge above their fellow practitioners? Their practices are on a level with that of the charlatan, and should be so treated. What right has such a man to endanger the lives of innocent but confiding patients—victims would be a better word—by such outrageous conduct. For the protection of women and children, at least, let all such pretenders be ignored.—*Joseph H. Mathews, Louisville, Ky.*

#### THE DEVELOPMENT OF THE FEMALE.

Between the ages of ten and eighteen years the change from girlhood to womanhood takes place. Anything which affects the general health of a girl between those years unquestionably produces a deleterious effect upon the generative organs if it continues for any length of time. I am perfectly satisfied that for a young girl to develop into a young woman she must have not only a sufficient amount of vitality to use for muscle and brain, and for the performance of the ordinary functions of the body, but she must also have a surplus, a reserve force, so to speak, otherwise the generative organs will surely suffer. The generative organs of a girl nine or ten years old are very much as they were when she was two years old; the circulation in these organs is inactive and their development is slow up to about the age of



ten, but from that time on they rapidly develop, and this requires a certain amount of vitality over and above what is needed or used up by the other organs. They are the last organs to develop, and, as we know, they are not essential to the life of the individual; a woman can get along very well without them, and if she has not a sufficient amount of vitality, those organs will be the first to suffer. I am sure that diseases of the womb are more common among the better class of women, where intelligence, money and sometimes doctors interfere with the law of survival of the fittest, at least in this country, than in any other. Some European writers, basing their assertion upon the number of gynecologists we have here, have even claimed that most American women must have uterine disease, but this I do not believe. Among the better classes, however, imperfectly developed uteri are very common. The reason for this, I believe, is that in this country the girls during their developmental stage, are not restrained in their studies, as English girls are, and are thrown more into company with grown people, their general education and knowledge of the world is greater than young women in other countries. They are sent to school when eight or nine years old, and between that age and seventeen or eighteen are supposed to acquire all the technical knowledge they are to have during life. Our young girls are pushed too hard at school; they do not have sufficient freedom out-of-doors. Their mental condition is developed at the expense of the physical, and during those very years the generative organs suffer most. If we permitted our young girls to lead quiet, healthful lives and would not try to educate them too early to act like grown people they would develop better physically, as young women in England and other countries do. After puberty their minds could be better developed than by hard and exciting work during the important period of physical development.

Generative organs which have remained undeveloped or have only partially developed readily become the seat of disease. Catarrhal troubles are apt to attack the organs, because the circulation is imperfect. These patients often suffer from a slight leucorrheal discharge, even before menstruation begins. Then, with the advent of that function, there will be pain, perhaps from the very first menstruation, or coming on soon afterward. This reacts on the general nervous system, digestion and assimilation become impaired, the general health becomes worse and this reacts again on the local condition. These young girls suffer from

anemia, from uterine polypi and hyperesthesia of the mucous membrane of the uterus. Suppose such a girl marries: if the uterus has developed sufficiently, she may become pregnant, but if the changes have progressed sufficiently she will probably remain sterile. Suppose pregnancy has taken place, however, and the case progresses to term. You cannot expect such an imperfectly developed organ to dilate as fully and allow the head to pass as readily as would be the case in an organ normally developed. A tear will almost certainly occur, followed by its usual train of evils, such as subinvolution, displacements, inability to take exercise, chronic constipation, etc., all arising from the imperfect development of the uterine organs.—*W. Gill Wylie, M. D., in Medical News.*

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In a paper on "The Diagnosis of Diseases of the Heart," Dr. Albert Abrams formulates his opinions thus:

1. The character or intensity of a murmur is no index to the gravity of the lesion producing it. The loudest murmur may be produced by the smallest lesion and vice versa.

2. The loudness of a murmur is largely dependent on the activity of the heart. Loud murmurs may become weak, and this change is an ominous sign indicating heart weakness. For the same reason they may disappear in febrile diseases and in the dying state. Faint may often be converted into loud murmurs after increasing cardiac activity by exercise and cardio-tonic medication. Complete compensation may often cause the temporary disappearance of a murmur.

3. In some individuals murmurs are louder in the recumbent than in the erect posture, especially murmurs of tricuspid and mitral origin. Murmurs should be auscultated with the patient in different postures.

4. Murmurs are less loud in inspiration than expiration.

5. Strong pressure on the chest, especially in children, may cause the disappearance of murmurs, the pressure inhibiting cardiac action.

6. When the heart is rapid or irregular in action, it is difficult to determine the time of a murmur. Remember that systolic murmurs are synchronous with the carotid pulse. Also regulate the action of the heart with digitalis.

7. Systolic are usually louder though less prolonged than diastolic murmurs.

8. When murmurs are faint, have the patient suspend respiration during auscultation.

9. Murmurs are most intense at their point of origin and they are propagated in the direction of the blood current by which they are developed.

10. Murmurs of extra-uterine origin are oftener found to proceed from the valves of the left heart, and in adults, murmurs at the tricuspid and pulmonary areas are rare.

11. In rare cases the murmur may be heard at a distance without laying the ear over the chest and they may be perceived by the patient. Only those arising at the aortic opening have this peculiarity.

12. When two murmurs co-exist at systole or diastole they may be transmitted or be due to disease at different orifices. Thus two murmurs occurring at systole may be due to mitral insufficiency and aortic stenosis, or if occurring during diastole, to mitral stenosis and aortic insufficiency. Differentiation is possible in two ways: First, by the character of the murmur. If one is blowing and the other rough, two distinct murmurs exist. If both are similar in character, then there is only one, which is transmitted from its point of origin at one opening to the second opening.

Second. Auscultate from the point where one murmur is heard to where the other exists, as from the apex to the aorta. If the murmur is everywhere distinct but it becomes gradually louder toward one point, then it arises at this point and is transmitted to other points. If, on the contrary, it is no longer heard at some point between the apex and aorta, and is again audible at the aorta, then there are two murmurs.

13. Never diagnose a valvular lesion without taking into consideration the effects of such a lesion on the heart and blood vessels and demonstrating them.

#### PAROXYSMAL TACHYCARDIA.

(Joseph M. Patton, M. D., in *The Journal*, 7-7 1900, Chicago.)

Of the two alterations of cardiac rhythm, paroxysmal is distinguished from symptomatic tachycardia as a pathological entity. Case reported with attacks of increasing frequency and severity. Symptoms: fluttering of the heart, nervous restlessness, no pain, difficulty in getting to sleep but sleep well after doing so, relief sudden, followed by exhaustion. Physical examination showed pulse rate 210, small volume, tension subnormal, tick tack cardiac sounds, with second sound higher in pitch, no palpitation,



tremor nor delirium cordis, no murmur nor dyspnœa. Slight displacement of cor to the left was found, apex normal.

Following morning, pulse was 70 and patient normal in all respects. For three months attacks recurred without discoverable cause, until one of five days' duration was followed by complete exhaustion, dyspnœa, cyanosis, cardiac dilatation and death.

Occurs most commonly in males between ages of 30 and 50 years. Various causes assigned by authors are fright, shock, pneumo-gastric paralysis, sympathetic over stimulation, cardiac dilatation, bulbar disease, tumor pressure, bulbo-spinal neurosis.

Postmortem the myocardium was found diseased in three of six cases.

Author holds that a neurosis must be present before reflex influences will have effect. Myocardial change often occurs but is rarely accompanied by tachycardia.

Of the morbid anatomy there is nothing definite. The chief points in diagnosis are the sudden onset, rapid, machinelike cardiac action, absence of palpation and dyspnœa and the abrupt termination of the attack.

Feelings of pain, uneasiness, numbness or tingling are rare.

Prognosis is unfavorable in recurrent cases. The usual care of cardiopathic conditions is applicable here. Sources of irritation if present, should be removed. Digitalis may be judiciously used for the dilatation. Stimulation of the vagi and chest compression as recommended by Rosenfeld were negative as also the local use of ice. Massage of the cor through the fourth and fifth spaces increased its strength though did not lessen the rate. Bromide of sodium, and when arterio-sclerosis is marked, strychnia, sodium iodide and sodium nitrite favor cardiac nutrition.

G. W. McCasky, M. D., called attention to a case of bradycardia with subnormal tension, in which amyl nitrite immediately quickened the heart action, but if allowed to go, exhaustion of the nerve-cells occurred with tachycardia. H.

Broadbent (Heart Disease, 1900.), advises venesection in mitral stenosis where signs of venous stasis begin to appear. Purgatives, to relieve the portal circulation, digitalis and strychnia should follow. In the event of objections to venesection seven or eight leeches may be applied over the liver with advantage. Digitalis is to be given with great caution and only when the patient is under direct observation. Vaso-dilators are of more advantage.

Maurange, in the *Medical Review* of April 1900, reports on poisoning during the administration of chloroform in a room lighted by gas. The worse the ventilation, the more gas jets, the greater the danger. Those present notice a tingling in the conjunctival nose and back of the throat, which rapidly extends to the bronchi, producing a dry, noisy cough, which becoming constant causes severe dyspnoea. The signs persist some time after returning to fresh air, and an acrid sensation remains several hours in the throat. The product of chloroform decomposition under these circumstances is carbonyl chlorid, or as Sir Humphry Davy designated it, phosgene.

#### SURGERY OF BILIARY CALCULI.

(W. D. Haggard, Jr., M. D., in *Journal* 7-7, 1900.)

Among other causes the elements of infection is emphasized. Mignot produced cholelithiasis by injecting bacteria into the gall bladder. Distinction drawn between the paroxysmal pain and the constant inflammatory pain.

Jaundice often absent, and present in other conditions. Kehr's mortality excluding cancer and advanced suppurative conditions was 3.8 per cent. in over 307 operations. Simple incision and suture of gallbladder to parietal wound. Wall off field of operation and use silk ligatures to hold bladder in control.

Fistulæ resulted in 50 per cent. of Robson's cases where bladder was sutured to skin, but in only 4.3 per cent. where joined to the aponeurosis—all closed later—cholecystendesis, the immediate suturing of the bladder after removal of the stones is reserved for early and simple cases.

Poppert, after removing the calculi, sutures a piece of rubber drainage tube into the bladder closing the incision above and not suturing the bladder to the parietal layers.

The simplicity, lack of adhesions, free passage of bile and safety from peritonitis are its advantages.

Cholecystectomy is performed

1. As a secondary operation for mucous fistula.
2. When the bladder is contracted and cannot be brought to incision if the common duct is free.
3. Where the bladder is very friable.
4. For malignancy, gangrene, ulceration.

Dr. Clinton Cushing holds the gall bladder to be a vestigial organ like the appendix and therefore should be extirpated.

Cholelithotripsy by finger pressure, padded forceps and needling.

H.

ALCOHOL AS A GENERAL STIMULANT AND HEART TONIC; ITS USE TO THE ANIMAL ECONOMY IN HEALTH AND DISEASE.

The question whether alcohol is a food has for a long time been discussed pro and con by writers on materia medica and theapeutics and by the expositors of social economics, but until recently no definite answer has been given, as most of the writers started out to prove that their side of the question was of necessity the only correct one. This was conspicuously the case with so-called temperance doctors and prohibitionists; for this reason their investigations had no scientific value, and consequently were worthless. They denied with vigor that alcohol had any food qualities, later they further denied that it had any stimulating properties other than that which it excited as an irritant. It is hardly necessary to say that this latter assertion is not worth refuting, for, in order to have produced the pathological phenomena so well described by themselves and admitted by all writers, it must first have excited and aroused into activity the stomach and circulation. This an irritant cannot do. Alcohol may after its local effect, continue its action as a depressant and narcotic.

Standard medical writers, however, have always taken the position that alcohol stands first in the select class of substances that may be rightly admitted to be general stimulants and heart tonics. They also go a step further and assert that it serves as a food in certain states of the body in health and nearly always when the body suffers from disease, and for that reason is a useful adjunct to the repertoire of the physician in his daily professional rounds.—*T. J. Hill, M. D., in Medical News.*

THE FORMATIVE PERIOD OF UTERINE FIBROIDS.

1. That chronic inflammatory conditions of the endometrium, uterine parenchyma, and of the ovaries and tubes are most powerful predisposing causes, and that there is a direct relation between the hyperplasia of the uterus and the formation of fibro-myomata.

2. That extreme disturbances of the nervous system precede and accompany the formation of uterine fibroids. Insomnia, headaches, and hyperæsthesia of the sensory organs are present to a greater degree than is usually found when the concomitant symptoms of the inflammatory condition of the uterus are present.

3. That the evolution of the fibroid from the fibromatous centres when it begins to take on growth is exceedingly rapid,



and that it is impossible to tell the age of the growth by its size. The rapid appearance and development are the reasons why so few fibroids are seen and examined in their incipency. That the size and rapidity of growth of a fibroid depend upon its blood supply, which is determined from the beginning by the location of the nidus, and therefore such conditions as pregnancy or the menopause could have little influence.

4. The possibility of the action of curettage as a predisposing cause for these tumors on account of the violence done to the blood-vessels, and of hastening their growth, because of concentrating the blood supply.

5. Keiffer has demonstrated that the blood supply is cut off from the uterine tissue, which then becomes condensed into whorls of fibrillæ which afterward develop into fibroids, obtaining their blood supply from the surrounding uterine tissue. He has shown that the tumors were composed of an histological structure in no way differing from the normal uterine tissue, save that which related to the concentric arrangement of fibrillæ. There was no evidence of embryonic tissue or new formation.—*Grace Peckham Murray in Medical Record.*

#### SOME POINTS IN THE THERAPEUTICS OF HEART DISEASE.

Very different from the indications furnished by acute carditis (including in this term its three forms of endo-, myo-, and pericarditis) are the conditions presented by acute parenchymatous degeneration. Thus the toxin of diphtheria is one of the most powerful proteolytic poisons known. It digests and dissolves living muscular tissue more powerfully than pepsin dissolves the muscular elements of food. Thus the living heart begins to fall to pieces under its influence, and to this is added a like degeneration of the heart's great adjuvant in the circulation, namely, the muscular layer of the arteries. A very striking fall in blood pressure, therefore, takes place, which goes on progressively increasing till death, as has been conclusively established in experiments with this toxin on animals, as well as clinically in the human subject. In striking contrast, therefore, with the flush of acute rheumatic carditis, a surface pallor is the characteristic hue of these patients, quite different also in its way from the bluish pallor of carbonic-acid poisoning. We often note the same pallor, with its accompanying rapid, small, and irregular pulse, to result from other toxins of the exanthemata. Now, there is one drug often mistakenly administered in these

conditions of heart weakness which is extremely mischievous, and that is digitalis. It is frequently prescribed with the idea that it is a heart-muscle tonic, and that, therefore, whenever we have a weak heart, we at once should give digitalis. But this term "tonic" is one of the vaguest terms current in our therapeutics, and that is saying a great deal. Thus we read of arsenic being a tonic, also iron, cod-liver oil, electricity, a cold bath, and a sea voyage. Anything, in short, that does good is called a tonic, the original conception evidently being derived from "tone" in music, as when the relaxed strings of a violin or of a piano are tightened or toned up. But vague terms lead to the loosest kind of practice, and what we need is to form very definite ideas about the specific action which we are aiming for under the term tonic. Now, the action of digitalis upon the heart is to throw its walls into an irregular kind of cramp. The heart, under its influence, has a mottled or nutmeg-like appearance, from the white, anæmic, contracted bundles compared with the more red, non-contracted neighboring strands. The general effect of its action, however, is to diminish the size of the heart's cavities. The drug, therefore, is of the greatest service when the heart walls are over-dilated and too much residual blood remains after each systole from inability of the dilated cavities to contract strongly enough to expel enough to expel their contents. Cramp the heart walls to one-half the abnormal width and the heart systole then will work to much greater advantage, on an easily understood mechanical principle.

But here comes the important fact about digitalis, that in order to produce its contractile effect it must have a more or less normal muscle fibre to work upon. It is utterly powerless with degenerated heart muscle, whether it be in fatty degeneration or in the parenchymatous degeneration of diphtheria, or by the weakening of the fever toxins as in typhoid fever. Not only is it then powerless, but it is actually harmful from its cramping rather than stimulating effect upon the heart's action.—*W. H. Thomson, M. D., in Medical Record.*

#### APPENDICITIS: ITS SURGICAL TREATMENT.

There is reproach to our surgery in the fact that many surgeons are selecting the simple recurring or so-called catarrhal cases for operative interference, refusing to operate upon the acute, virulent or infectious cases. A good young surgeon of my acquaintance, referring to his own work, stated that he had done

thirty-two operations with one death, and that he had rejected six cases too far gone for surgical interference. He should have saved two or three of the six rejected cases. Twenty per cent. is too many to reject. However dire the condition, the one chance for life should be given. While there is breath, while there is a heart throb, operate. There are no "edges" or "border lines" that should be feared; there is peril in appendicitis in any and all its forms, and its every stage. There is more peril in that timidity which prompts and leads to delay than in that courage which hazards the one almost certain chance of relief, by prompt, thorough and complete surgery; the one saves where saving is possible, the other kills. We will have better success, a more unbroken and uniform triumph in dealing with this trouble when we dispense with toying.

We should not wait for "strong evidence" of perforation, abscess, general peritonitis, rapid, weak pulse, anxious respiration, distention of abdomen, though even when these symptoms are present the patient may be operated upon and saved. Even in mild cases the element of probable recovery should not be considered; there should be a clean removal of the appendix, for we all know as a rule these cases recur; there is a continuous peril hanging over such patients, and there is a strong temptation to treat them in the same temporizing way as in previous attacks, until finally death results. It should be kept in mind that making statistics is not in this business, but life-saving is. The appendix is fortunately at a very convenient point for good surgery. There is no good surgical excuse for ever leaving it, certainly not the excuse that it cannot be found. Such an excuse is a reproach upon the courage of the surgeon, for it can always be found; only the timid fail to find it.—*Joseph Price, M. D., in Medical Herald.*

#### DANGEROUS PULMONARY HEMORRHAGE IN TUBERCULOSIS AND ITS MANAGEMENT.

The drug most often used by the profession, after morphin and atropin, is ergot—a drug that should never, under any circumstances, be given for this purpose. If it has any physiologic action on the bleeding vessels it is to increase the blood-pressure within them, and thus imperil the fragile walls of those in the diseased area. The only real reputation for proved usefulness that ergot has ever acquired is based on the theory that it causes contraction and increased tension in unstriated muscular fibers; all



the investigators have claimed that it so acts, and it is employed for the contraction of the uterus in hemorrhage on that theory, as it is in certain uterine tumors—not for its power to contract the blood-vessels, but rather the mass of the uterine muscular fibers, and so compress bleeding vessels and expel tumors.

If it has such an effect on the blood-vessel walls, as it undoubtedly has, it must influence them all, and so increase the blood-pressure, and this is found to be the case. Every particle of increase of general blood-pressure by so much increases the danger of a rupture at the weakest spot, and the weakest spot is where the vessels walls are brittle from disease. Why the profession will continue to use the drug, with the common knowledge of its physiologic action, is past understanding, except on the theory that fashion and custom are with many of us liable to take the place, in our mental processes, of science and reasoning, and even of common sense. To me, the use of ergot for dangerous pulmonary hemorrhage is tantamount to malpractice.

Of all the measures ever used for this accident, probably morphin—preferably with a proportionate admixture of atropin—administered hypodermically, is more valuable than all others put together. It may be used rather freely; it should never be used recklessly. A quarter of a grain may be given every half hour, for two doses, if the urgency of the case demands it; then the intervals should be lengthened, and the effect on the nervous system carefully watched. The amount given should be gauged by its effect on the nervous system, not by its control of hemorrhage. Slight somnolence should be produced, nothing more. With knowledge of a vast number of cases where this medication has been used, I have no memory of a single instance where a poisonous or harmful effect was produced by it.

The patient should have loose clothes, and his extremities should be kept warm, by artificial means if necessary, as this favors distension of the superficial vessels. Nervousness, and especially fear and apprehension of calamity, must be avoided. To this end the positive assurances of the doctor are often valuable, but in most cases of any severity, a dose of morphin and atropin should be given hypodermically. Such a dose makes the patient forget his trouble and danger, and gives him a sense of great tranquility. The heart force, when it is beating violently, may with benefit be reduced. To this end aconite and veratrum may be used, even in more liberal doses than is usual; but it should always be remembered, in giving these drugs, that absorption from

the stomach is likely to be slow, and that we are liable, if we give repeated doses, to discover a cumulative effect, and possibly a poisonous one, a few hours after beginning the use of the medicine. One drop of the tincture of aconite or veratrum, or one of each, may, with propriety, be given every half hour, for several doses; then every hour, till a distinct effect is produced. Blood-pressure in the chest may be reduced by dilating the vessels of the extremities. To some degree morphin and atropin do this, so there is a double purpose in using this combination. I do not forget that it is alleged, perhaps correctly, that the blood-pressure is increased by these drugs, yet I believe that in cases of severe pulmonary hemorrhage the pressure inside the chest is relatively reduced by them; certainly their great value in tranquilizing the patient overbalances, ten-fold, any slight harm they might do.—*Norman Bridger, M. D., in Jour. A. M. A.*

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**Sulphur as a Preventive for Mosquito Bites.** One of our readers informs us that, having seen a statement in some English medical journal to the effect that sulphur, taken internally, would protect a person against flea bites. Accordingly, he began taking effervescing tablets of tatarlithine and sulphur, four daily. He provided himself with several lively mosquitoes and, having put them into a wide-mouthed bottle, inverted the bottle and pressed its mouth upon his bare arm. The mosquitoes settled on his skin, but showed no inclination to bite him. If this gentleman's experience should be borne out by further trials, it might be well for persons who are particularly sensitive to mosquito bites to take a course of sulphur during the mosquito season, especially in view of the growing opinion that the mosquito is the common vehicle of the plasmodium malariae.

**Arizona's Jeweled Trees.** At the request of the General Land Office, Mr. Lester F. Ward recently explored the fossil forests of Arizona. The richest deposits of silicified trees cover an area of about eight miles square in Apache county. In some parts of this area the petrified logs lie much more thickly than they could have stood while living, and Mr. Ward thinks they must have been transported by swift currents of water in the mesozoic era. Microscopical inspection of the texture of the agatized wood proved that it resembled the araucarian pine of the southern hemisphere.

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## Editorial.

### WHERE ARE MISSIONARIES NEEDED?

The whole civilized world professes itself horrified at recent Chinese atrocities. Certainly such offenses against civilization are not to be justified, nor even tolerated; and yet, if one pauses to consider how things must appear from the Chinaman's point of view, how his religious zeal is stirred and his patriotism is appealed to as he sees uninvited and unwelcome foreign encroachments on every hand, his frenzy seems to us more excusable and



his murders no more cruel than many that are done in open daylight and under the protection of the law in this country.

Isolated cases of manslaughter as performed by the Christian Scientists, faith-cure cranks, *et al.*, are common throughout this country and scarcely excite more than transient comment. Occasionally whole families are sacrificed, and sometimes a large number of persons in one community. A recent instance is that near Rockford, Illinois, in which the followers of Abram Zook, with some twenty-five cases of diphtheria, at last accounts, were in a dying condition, and either refusing or forbidden by their leaders to use any medical treatment for their relief. Imagine, if you can, the conditions prevailing in that farmhouse, with those deluded or helpless victims suffering and dying with malignant diphtheria and not allowed even the ordinary treatment. What must be the cruelty in the hearts of those in authority in that community to enable them to witness such scenes and refuse rational means of relief to the afflicted. Medicines left there by physicians remain untouched. Even common hygienic measures are not allowed. And yet, it seems that sane and pitying citizens who witness such outrages are powerless to interfere. Such practices are protected by the medical law of Illinois, which reads as follows:

"Sec. 7. Definition of this Act.—Any person shall be regarded as practicing medicine, within the meaning of this act, who shall treat or profess to treat, operate on or prescribe for any physical ailment or any physical injury to or deformity of another. Provided, that nothing in this section shall be construed to apply to the administration of domestic or family remedies in cases of emergency, or to the laws regulating the practice of dentistry or of pharmacy. And this act shall not apply to surgeons of the United States army or navy, or marine hospital service in the discharge of their official duties, *or to any person who ministers to or treats the sick or suffering by mental or spiritual means, without the use of any drug or material remedy.*"\*

Is it any wonder that the sturdy farmers of the neighborhood are threatening to lynch Abram Zook and his aides? A fox that steals poultry, or a dog that kills sheep may be killed; but such a wolf as Zook, whose victims are human beings, is protected by the law.

And all this is done here in enlightened America, and in the name of religion—in the name of Christianity—that religion

\* The italics are ours.

which many persons are making strenuous exertions and spending large amounts of money to convey to the benighted heathen of Asia, whether the latter want it or not. Are these practices in accordance with the Christian religion, or with the high state of civilization which we boast. If not, and this is an enlightened land, why are such practices allowed? If this is not a Christian country, nor yet highly civilized, why are not the missionaries employed here until this country is converted, and we can show a decent example of what a Christian country is? To a man up a tree it would appear that we are not yet so much better than the rest of the world that we have goodness and grace superabundant and to spare for the export trade. It is all needed yet for home consumption, and if a still larger supply could be secured, there would be no danger of overstocking the domestic market. It is not to be expected that every individual in the States be made orthodox, but it is not too much to require that Christianity should purge itself of this rottenness of "Christian Science," and that it aid the medical profession to secure legislation that will prevent manslaughter from masquerading in the guise of either science or Christianity.

Missionaries are as much needed here at home as in China.

\* \* \* \* \*

We are in favor of missionaries. So much so that we think that every man, and certainly every physician, should do missionary work. When we come upon times like these when the lives and health of citizens are jeopardized and destroyed by false teaching, it is our duty to spread the gospel of common sense, of true medical and sanitary science, of rational legal protection against such insane fanaticism or heartless hypocrisy as that of Mother Eddy and her apostles and all of that ilk. Not that Eddyism is of such lasting importance. It is too absurd to hold out long, and never would have had any vogue but for its cloak of religion. It will pass away after a while—after it has claimed a few hundreds or thousands more victims. But something else will take its place, and we must still wage our war against superstition, ignorance and charlatanism in whatever form they may appear.

\* \* \* \* \*

In this connection we are reminded of and would like to draw the attention of our readers to a recent book entitled, "Christian Science. An Exposition of Mrs. Eddy's Wonderful Discovery, including its Legal Aspects. A Plea for Children

and other Helpless Sick," by William A. Purrington. This little book, published by E. B. Treat & Co., gives an excellent account of Mrs. Eddy and her writings, and the whole cult. It displays the ignorance, the vagaries, the greed, the blasphemy, the dishonesty of that vain and silly old woman and her followers and the simplicity of their dupes. The author, Mr. Purrington, is not a doctor, but a lawyer, who has given much study to medical law. He was counsel of the medical societies of the state and of the county of New York in drafting and securing the enactment of the medical statute of that state, and is a lecturer upon law in relation to medicine, and an experienced writer upon legal topics in first-class publications. In this book will be found a great deal of information, not only upon "Christian Science," but upon medical science in their attitude before the law. Speaking of the physician's duty as a missionary, Mr. Purrington's is a good book for every doctor to read first and then loan to everybody he can induce to read it. That will be doing good useful missionary work.

S. W. KELLEY.

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### IN BEHALF OF THE NURSE.

We are glad that Miss McMillan, the capable superintendent of nurses at Lakeside Hospital, has spoken so to the point in her article on "The Modern Nurse," in the July issue of the GAZETTE.

Much might be said upon this subject, and from the various standpoints of the patient, the family, the physician and the nurse.

No one can serve two masters and do justice to himself, and because the nurse, in virtue of her calling, must do her duty towards each one of several heads, so to speak, it often renders her position a peculiarly trying one, and sometimes results in her pleasing nobody.

Although the professional nurse of to-day is the right hand of the physician, nevertheless we doubt if the medical profession as a whole, fully appreciates much that the nurse has to contend with. Far less do the laity understand it.

The nurse is not paid by a corporation or a society, where the individual tax would be but small, but by a single family, who must stand the entire cost. Hence, while nurses as a class are poorly paid—even when they receive the maximum rates—fifteen or twenty dollars a week seems a large sum to the usual



family, and there is a natural tendency to secure the necessary service—the quality of which they are seldom in a position to judge—for the least money.

This tends to cheapen the profession, and in a large measure is the excuse for the existence of the untrained nurse, who values her services at very much less than does her trained sister.

Again we find the hospitals partly responsible for this condition of affairs.

In these institutions, rooms and nursing may be had for much less, usually, than the charge for nursing alone would amount to in one's own home.

In some of our eastern cities they have a sub-class of the nursing fraternity known as *attendants*. These women have all attended lectures on the care of the sick, etc., and are qualified to assume charge of a case after it has passed the stage that demands the watchfulness and skill of a trained nurse. They receive for their services about seven dollars a week.

Some such arrangement might be introduced with advantages into every city, and yet it would not be without its injustices to the graduated nurse. She would then be called upon to care for the patient during the acute stage of illness, where all her resources would be over-taxed in rendering service far in excess of the remuneration therefor. When the time arrives when she might relax her exertions, and square the account, in a measure, her services would be dispensed with for some less expensive attendant.

It should be the duty as well as the privilege of the medical profession to encourage and maintain the highest standard among its nurses, and we believe that this can be best effected by approving of an honest and just rate of pay for the nurse, and at all times to endeavor to secure high-grade service.

The GAZETTE bespeaks a kindly consideration for the professional nurse, and at any time it would be glad to hear the views of others upon the subject.

G. SEELEY SMITH.

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### THE PHYSICIAN'S VACATION.

"All work and no play makes Jack a dull boy," is an old adage and holds true equally well with the physician as with any other person engaged in daily routine. A physician, dulled for want of vacation and rest, is not capable of giving to his patients the best that is in him. His perceptive qualities are not so acute

to observe the more obscure points which aid in the diagnosis of difficult cases. Neither can he be so cheerful and encouraging—two indispensable qualifications—in the presence of his patients when he is feeling thoroughly tired and worn out.

Every physician has perhaps realized or has heard that there is twice during his professional career when it is difficult to take a vacation. First, as a beginner in practice when the financial question may be one barrier and eagerness not to miss a client another barrier. Second, as an established practitioner with a large clientel; as trusted family physician and counselor as to health. Under the first condition it would be pardonable for the physician to abstain from taking a vacation as he cannot lay claim to exhaustion from overwork. With the second condition, however, we believe the physician should consider it a duty he owes to himself and his clientel to take a vacation every year.

How the vacation shall be spent is a matter to be decided by the inclinations of the different individuals. Get away from home and have change of scene and complete relaxation from professional duties is the ideal vacation. Some, wishing to improve their opportunities, may seek the larger centers of population, and, by attending the hospitals, add to their professional knowledge.

Insurance companies have a rule for estimating what is termed the "expectation of life." It applies to ages under 60 years and is as follows: Subtract the number representing the individual's present age from eighty; multiply the difference by seven-tenths and add the product to the present age. Thus the expectation of life for three men aged 30, 40 and 50 years is 65, 68 and 71 years respectively. Now, it is a well recognized fact that the average life of the physician is shorter, by from five to ten years, than that of the business man and those engaged in other professions. This fact alone should be incentive enough for the physician to make it a rule to have an annual outing. What he loses, financially, each year during his absence can, we believe, be made up during the balance of the year by being able to accomplish more work in the same time.

The question as to why physicians do not live to be so old as those engaged in business life and other professions, we do not propose to discuss. We believe the remedy lies, in a great measure, with the individual, and that an annual complete relaxation from daily routine and professional worries would have a decidedly beneficial effect.

E. S. LAUDER.

## ERRATUM.

Through some oversight, the following list of books was placed under the heading, "New Books," in the July issue, whereas it should have been under the heading, "New Books Added to the Cleveland Medical Library:"

From Dr. C. J. Aldrich in exchange:

Kyle, D. Braden, M. D. A text-book of the Diseases of the Nose and Throat. 1899.

From D. Appleton & Co.:

Trans-American Laryngological Association. 1899.

From Dr. Stewart Leroy McCurdy (author):

Manual of Orthopædic Surgery. 1898

From secretaries:

Transactions of the New York Obstetrical Society. 1898-9.

Transactions of the Louisiana Medical Society. 8 vols., 1888-1893, 1894, 1895.

From Associations of Medical Librarians:

Donders, F. C., M. D. Anomalies of Refraction. 1899.

Duhressen, A. Practical Gynecology. 1895.

Gould, G. M. Student's Medical Dictionary. 1899.

Shaffer, N. M. Orthopædic Surgery. 1898.

Roberts, J. B. Fractures of the Radius. 1897.

Morris, H. Renal Surgery. 1898.

Morris, H. Human Anatomy. 1899.

Stohr, P. Text-book of Histology. 1898.

From Dr. Abraham Jacobi:

Festschrift in honor of Abraham Jacobi, M. D., etc., "International Contributions to Medical Literature."

Purchased:

Fenwick, Samuel, and W. S. Fenwick, M. D., Ulcers of the Duodenum and Stomach. 1900.

Mitchell, S. Weir. Fat and Blood. An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria.

St. Bartholomew's Hospital Reports. Vols. 28, 1892; 30, 1894; 31, 1895.

Transactions of the Clinical Society, London. Vols. 6 to 26, 1873-1893.

Bibliographia Medica (*Index Medicus*.) Nos. 1-4, January-April, 1900. Monthly.



## Periscope.

*Nutritive Value of Alcohol.* By WIEBUR O. ATWATER (*Proc. Amer. Physiolog. Soc.*, Dec. 1899).—Experiments on men show that alcohol serves the body as fuel, as do fats and carbohydrates. Ninety-eight per cent. of the alcohol given was oxidized in the body, and the alcohol supplied about one-fifth of the total energy during rest, and about one-seventh during work.

*Plasmon.* By HEINRICH PODA and WILHELM PRAUSNITZ (*Zeit. Biol.*, 1900, 279).—Plasmon is a new preparation from the proteids of milk. The experiments here recorded, which were carried out on human beings, show that it is easily digestible and assimilable, and that its nutritive value is equal to that of meat.

*Assimilation of Iron.* By EMIL ABDERHALDEN (*Zeit. Biol.*, 1900, 193).—The numerous experiments here recorded on various animals relate principally to the estimation of hemaglobin. They support the author's previous contention that the iron of inorganic compounds, of hemaglobin, and of hematin in the food, is absorbed and utilized in the manufacture of hemaglobin.

*Nitrogenous Metabolism after Splenectomy.* By LAFAYETTE B. MENDEL and HOLMES C. JACKSON (*Proc. Amer. Physiol. Soc.*, Dec. 1899).—In view of the part supposed to be played by the spleen in uric acid formation, it was found that, in cats and dogs, removal of this organ does not lessen the normal output of uric acid, after diets of different kinds. The ability of the organism to form allantoin after ingestion of thymus or pancreatic tissue is in no way diminished.

*Influence of Iodin, sodium iodid, and Iodothyryn on the Circulation.* By A. G. BARBERA (*Pflueger's Archiv*, 1900, 312).—Largely polemical. Laudenbach has found that iodothyryn has not the action on the circulation described by von Cyon. He, however, used Notkin's preparation, which appears to be very toxic, whilst von Cyon used Baumann's iodothyryn. The latter lowers the blood pressure and the heart rate, whilst Notkin's preparation acts in the opposite way. Iodin and sodium iodid act like Notkin's preparation, stimulating the cardiac accelerators and vaso-constrictors, and depressing the inhibitory nerves of the heart and blood vessels.

*Action of the Blood-Gases on Breathing.* By W. PLAVEC (*Pflueger's Archiv*, 1900, 195).—The difference between the

action of deficiency of oxygen and increase of carbon dioxid in the blood is greater than has been supposed. With small carbon dioxid tension in the blood, such as is obtained by breathing air containing 5 per cent. of the gas, there is only an action on the respiratory movements, but with greater tension the respiratory center is greatly stimulated. The theory of Hermann, that the deficiency of oxygen raises the irritability of the center to carbon dioxid, has no foundation; in fact, there is a progressive lessening of its excitability. The terminal inspirations of acute asphyxia are caused by the accumulation of carbon dioxid in the blood. The breathing in of this gas causes an increased rate of respiration, and its presence in the blood is the normal stimulus to produce breathing.

*Alopecia Syphilitica.* (*Riforma Medica*, Aug. 23d, 1899).—The hair to be kept short, and rubbed with the following alternately daily:

Hydrarg chlor corras...	0.2		
Chloral hydrat.....	4.0		
Resorcinol .....	0.2	Hydrarg chlor mite....	2.5
Ol. Ricini.....	1.0	Ac. Salicylic .....	0.5
Spts. vini 90 per cent. ad 200.0		Nugt. Petrolii.....	50.0
Misce.		M.	

If seborrhœ and pityriasis of the scalp exist at the same time the following is useful:

Sulphur. Praecip.....	1.5
Nugt. Petrolii .....	30.6
M.	

*Atropin in Ilens.* BATSCH, Grossenhain (Saxony), reports two further cases of ilens which were cured by large doses (one-twentieth to one-twelfth grain) of atropin.

*Local Anesthesia.* DOBISCH (*Rev. Medicale*, Oct. 1899).—Obtains local anesthesia lasting 2–6 minutes by spraying with a mixture of chloroform 10, ether 18, menthol 1.0.

*On the Influence of Ichthalbin on Metabolism and the Intestinal Functions of Children.* By ROLLY and SAAM (*Muench. Med. Wchschr*, 1900, 460).—The authors consider Ichthalbin to have a beneficial influence on metabolism, supporting the findings of Suelzer, as well as Helmers. The diminution of intestinal putrefaction was as readily obtained, as with iodoform or calomel.

SPENZER.

## New Books.

**A DICTIONARY OF MEDICINE AND THE ALLIED SCIENCES.** Comprising the Pronunciation, Derivation, and full Explanation of Medical, Pharmaceutical, Dental, and Veterinary Terms, Together with Much Col-lateral Descriptive Matter, Numerous Tables, etc. By Alexander Duane, M. D., Assistant Surgeon to the New York Ophthalmic and Aural Institute; Revisor of Medical Terms for Webster's International Dictionary. Third Edition. Enlarged and Thoroughly Revised. With eight full-page colored plates, \$3.00. Lea Brothers & Co. Philadelphia and New York.

In entering upon the study of medicine the student must learn so many new terms that it may be said he practically learns a new language. If he would be thorough in his work, both in the learning of those terms and the understanding of them, he should provide himself with an up-to-date medical dictionary. To the practicing physician, also, such a book is indispensable, for the rapid advance of medical science is constantly demanding the coining of new words.

In the book above described, containing 646 pages, we believe the undergraduate and physician will find the full requirements of a medical dictionary. Among its various excellent qualities it contains eight full-page colored plates as follows: 1. Bacilli and Micrococci; 2. Casts and other Urinary Sediments; 3. Centers of Cerebral Cortex; 4. Human Embryo; 5. Leucocytes and Erythrocytes, Normal and Abnormal; 6-7. Malarial Plasmodia; 8. Staphylococci and Streptococci.

Last, but not least, among those qualities it contains what is omitted in two other medical dictionaries in my possession, that is, the pronunciation in phonetic spelling after each word that really requires it.

E. S. LAUDER.

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**THE ANNUAL OF ECLECTIC MEDICINE AND SURGERY.** Record of 1897 and 1898. Edited by John V. Stevens, M. D. Professor Diseases of the Nervous System in Bennett Medical College, Chicago, etc. The Scudder Bros. Co., Publishers, Cincinnati, O.

This is the eighth of a series of volumes, consisting of papers read before the annual meetings of the various State Eclectic Societies.

The range of subjects dwelt upon is large, many of the papers being very excellent and showing much originality of thought and careful investigation.

All papers are treated from an eclectic standpoint.

CLARK.



## Society Proceedings.

May L. Bassett, Medical Reporter.

### CUYAHOGA COUNTY MEDICAL SOCIETY, JULY 5, 1900.

The regular meeting of the Cuyahoga County Medical Society was held at the Library Building, 586 Prospect St., on Thursday evening, July 5. The meeting opened with the President in the chair. The minutes of the last meeting were read and approved, as also the quarterly report of the Treasurer after the report had been audited.

The report of the committee appointed to visit the Health office of the city and determine if possible whether the system of classification of deaths could not be changed to the Bertillon system, was called for, and the chairman, Dr. Handerson, reported as follows: That the Health Office would be willing to adopt the modified Bertillon system, as soon as it was revised and published, but that it is doubtful if any change could be made in reference to allowing undertakers to report the probable cause of death without a medical decision.

The Health Officer thought the errors resulting from the latter method could hardly be avoided, as he did not think it feasible to change the custom in this particular. The report was received and committee discharged.

The program was then called, the first paper being that of Dr. W. E. Lower on "Appendectomy in the Quiescent Stage."

Dr. Lower's paper appears in this issue of the GAZETTE.

Discussion:

*Dr. Quirk:* Two or three cases of appendicitis have come under my observation recently which had been operated, and who were wearing abdominal supporters at the request of the operating surgeons. At this time of the year they are, of course, a great annoyance to patients, and I have been asked how long they would be obliged to wear them, and I did not know until recently that it was the custom with surgeons to require it after the operation. I do not know how prevalent the custom may be. Another question is the possibility of danger to these patients going out of the city at this season of the year, they might not be where they could be operated if an attack proved dangerous. Another question that comes to my mind is with reference to the need of care in diet. These patients have been told to eat sparingly. I, for one, cannot see how eating heartily is going to affect a case of chronic appendicitis. Nutrition is lowered thereby, and if nutri-

tion is lowered the resistance of the patient is decreased, and it looks to me as if the patient's chances of evading an attack are increased accordingly. I have two or three patients who have been keeping themselves on a very light diet for fear of recurrent attacks. I do not know how common it is for physicians to advise patients to this effect. I do not consider appendicitis a medical disease. It should be treated surgically from first to last, and I do not see how diet can affect it. It is purely a germ disease and no medicine has ever been known to affect them outside of the alimentary tract.

*Dr. Bunts:* I am surprised that there is no more discussion of this topic than there is to-night. I never heard the subject brought up before but there was a spirited combat. I recall a paper read at the American Medical Association, by Dr. Deaver, upon appendicitis, in which an active part was taken in the discussion by Drs. Senn, Keen and others. The trend of the discussion was something like this: Dr. Senn thought it very fortunate for the medical profession that a man like Dr. Deaver, who advised operation in all cases of appendicitis, was not an instructor in our colleges, and Dr. Deaver thought it a great misfortune to the public that a man like Dr. Senn was allowed to hold a college position and teach students the subject of appendicitis in the manner he did; so it would not be surprising if in matters relating to this topic tonight there should be a wide difference of opinion among us. For my part, I agree with Dr. Lower that when circumstances are favorable cases should be operated immediately, but the question as to whether the case is favorable for operation covers considerable territory and a good many things. It does not mean that the surgeon should operate every case of appendicitis. I can readily imagine cases in the country or under other circumstances unfavorable for operation where the per cent of death rate would be greatly increased, but in the city where everything is favorable, suitable rooms and nursing, with perfect asepsis, and in the hands of men who are familiar with the dangers resulting from imperfect technique, I think operation should not be delayed. However, I consider it very bad form for a man to get up in the American Medical Association and make the assertion that all cases should be operated. If all men were well versed in the surgical technique and had ample experience in dealing with this disease, it would be different, but to make such a statement before many men who have had no operation experience in handling appendicitis is, I think, a very unwise thing to do. It is a dangerous

statement. I know of several cases in this city of simple appendicitis, which were operated between attacks and the cases lost. Whether the case would have recovered in other hands, I am not prepared to say, but at any rate the patient died, and why we do not know. It is not fair to take the statistics of surgical operations and formulate a rule upon this for everyone to follow. I think the best rule is the old one, that operations for appendicitis must depend upon many things, but in the hands of skilled operators and under favorable circumstances I should say operate immediately, as soon as the diagnosis is made. I think Dr. Lower said possibly if the case were in the hands of an intelligent physician, who could see it every few hours and watch it carefully, it might be safe to wait. Now I do not believe that he meant that exactly, for I think that if we accept the statement that every case should be operated if circumstances are favorable, then there can be no excuse for waiting. If everything is favorable, there is nothing that can excuse the delay of an hour. There is not a surgeon or medical man of unlimited experience even who can tell when a case may go on to rupture. We have had too many cases in which appendicitis has proved fatal to make waiting perfectly safe. No one can tell when a fulminating case may result, and there is no excuse for taking such risks if circumstances are favorable for operation.

The question of herniae and fecal fistulae is an important one, and though personally I have never seen hernia when the wound had healed by primary union, I do not say that it may not occur. I have seen hernias where the case had to be drained, and that to my mind is a very strong argument in favor of early operation before abscess has formed. Hernia is of great danger, especially to the man of active pursuits, and this should be taken into consideration. I have never seen a fecal fistula form in an operation where there had not been a rupture of the appendix, and I say this regardless of the kind of suture or method of closing the stump, and I consider this to be an important argument in favor of early operation.

Dr. Quirk has spoken of bandages after operation. I do not know whether they are of any use or not. I know in fleshy people they are a great comfort, and patients who have become accustomed to them will rarely give them up. In thin people I have an idea that they are of little use.

In regard to eating, I think Dr. Quirk has stated the case very favorably. I think, however, that there might be a case of catar-



rhial difficulty in which food might make the patient worse, but the general principle of good feeding should prevail.

*President:* What do you think with reference to constipation as a cause of appendicitis?

*Dr. Bunts:* I think constipation may be a fruitful cause of appendicitis, because it is usually followed by attacks of diarrhea, which set up irritation, which may be an exciting cause.

*President:* Another question I would like to ask. Is not the cause of hernia sometimes due to division of the nerves to the muscles, and would it not be well to carefully avoid their section?

*Dr. Bunts:* Yes, I think care should be exercised in these cases, for hernia might result from divided nerve trunks and consequent muscular atrophy. But the danger is usually small in these operations.

*Dr. Tuckerman:* A year ago at the American Medical Association, a gentleman collected reports of all cases of appendicitis for the two preceding years, and he found that the death rate of early operations was higher than that of operations occurring somewhat later in the stage of the disease, that is, when the acute stage had passed off and the disease was more quiescent. I think that as we grow older we are less inclined to adopt a uniform and unvarying course of procedure. We hold all principles with a little more laxness and have a little more charity for other people's views, and while, as I have grown older, I advise operation oftener than I used to do, I think the doctor as he grows older will see many cases in which he will feel that it is wise to wait. In the quiescent stage when the serous membrane of the peritoneum is uninflamed, the incision may be shorter and the resulting danger is almost *nil*, and therefore unless you get to the case in the first hour or so, it may be better to wait until the quiescent stage provided the symptoms be not urgent. As to when to operate after an attack has passed off, I can say that personally I have always depended a good deal upon the question of tenderness in the abdomen. Cases in which tenderness has promptly and entirely departed have not, so far as I have seen, been recurrent. I am in the habit of advising operation when tenderness remains after the attack passes off.

*Dr. Quirk:* I would like to speak a moment upon an article I saw the other day, not exactly upon this topic, but relating closely to it. It was published in the *Lancet* in 1884, I think, but I forget the name of the writer. It referred to the nutrition of the appendix, and I recall in post mortems I have made, and the few

cases upon which I have operated, the anatomical relation of the parts as mentioned in this article. It was to the effect that the distal portion of the appendix has no mesentery and receives no direct nutrition, but instead receives it from contact with vessels passing from approximal to the distal end. If you will notice this, you will see that the outer end of the appendix is entirely free from securing direct nutrition. The writer attributed this as one cause of necrotic and chronic forms of appendicitis.

*President:* If I may be permitted a word upon this topic, I would say that one man's individual experience is worth little in this world, and yet a man's experience in his own practice largely determines his opinions, perhaps more than it should. One thing that the public at large is afflicted with is appendectomania. They are really insane upon this topic. An attending physician, even if he suspects appendicitis, hardly dares mention it, or before he can get back to his office one or two surgeons may be called to operate. It is not an uncommon thing to have a case of typhoid that simulates appendicitis. I recall such a case in which there was every symptom of appendicitis, except possibly that there was no mass to be felt. Now supposing that the diagnosis of appendicitis had been made and the rule of immediate operation followed. As you well know it is a serious thing to put a knife into a typhoid patient, though it is something that has been done more than once. I think when the diagnosis might be in error, a physician goes a little too far to say that all cases should be operated immediately. If you say that to the public, they will say next that it is impossible for a case to recover without operation. Those of us who had cases in the days when we had typhlitis, perityphlitis and paratyphlitis know that most of them did recover, yet it is certain that if we had those cases now we would call them all appendicitis. I recall a case not very long ago which I was called to see—a man who was vomiting terribly and whom I thought had an appendicitis, but I knew him to be a hard drinker. He admitted having had ten glasses of beer that evening and during the night both whisky and brandy freely—he was intoxicated. I made the remark that I thought he had an attack of appendicitis. Well, when I returned to that case, which was in a few hours, I found my patient had already gone to the hospital. Now, were I a surgeon, I do not think I would have wanted to put a knife into that case.

There is another danger to be guarded against in these cases and that is hyperesthesia. I had a case of a young married wo-

man recently who was not feeling well; had not been married long, a bright, intelligent woman, who complained of general abdominal pain and tenderness, and naturally thought the appendix was to blame for the trouble. When she came to me for examination the appendix was felt for, as she complained of pain in that region, and I thought I could feel a mass of some size in that region. On the next day I found an equally sensitive place on the opposite side, and it proved to be a case of bilateral hysterical hyperæsthesia of the ovarin region.

Now in regard to the statistics which give the number of cases lost as one per cent. Let me say that I heard no less an authority than Dr. Keene say that when a man says that he can take one hundred men and operate upon them with but one death, he does not know what he is talking about, for there is no surgeon who can open one hundred normal abdomens and have less than two per cent. death rate. And I think you will agree with me that Keene is as likely to be able to operate without a single death as any operator.

*Dr. Tuckerman:* It is well for us to remember that in making up these statistics we do not take into consideration the coefficient of error. It takes ten thousand consecutive cases to reduce the coefficient of error in the percentage of mortality to one per cent. That is, to bring the statistics to a point of accuracy where the one per cent death rate shown may not, on account of the one per cent coefficient of error become two per cent in the next list of cases. That is a straight mathematical fact that must be taken into consideration in all statistics or you cannot be sure of their accuracy.

*Dr. Lower:* In regard to Dr. Quirk's question, I think Dr. Bunts answered it very satisfactorily. I would recommend an abdominal supporter only in those cases in which the abdomen is very pendulous. I think very probably many surgeons do recommend it on account of the wound. This, however, is unnecessary if the muscles are not divided and you get a primary union. In regard to diet, I would say that care in this matter is the natural result of fear upon the part of the patient who has had an attack of appendicitis. He is constantly afraid, knowing that he is carrying about with him a bomb that may explode at any time, and he grows annoyingly careful about diet and exercise. In regard to Dr. Bunts' remark, he correctly understands my attitude in ap-peneicitis. I do insist upon an immediate operation as soon as the diagnosis is made if the conditions are favorable, and these



conditions he has well described. But there are certain cases which we are called to see in consultation when the symptoms are mild, vomiting, pain, some tenderness, but no constitutional symptoms, pulse only slightly accelerated and temperature normal. Here you are in doubt as to diagnosis. At the end of ten or twelve hours the symptoms may all subside and the case go on to recovery. On the other hand the symptoms at this time may suddenly become worse. There is no doubt in your diagnosis and you advise operating immediately, yet all this time you have been waiting your case has had appendicitis. The first change noticed may be in the pulse, or increased abdominal tenderness, rather than rise of temperature. In regard to Dr. Tuckerman's test, I would say that you often do find tenderness on deep pressure at the base of the appendix, it being the only symptom present. As to the second and third attacks after operation, I am not familiar with such conditions. I believe it is a good thing to avert the stump of the appendix, to avoid adhesions and prevent symptoms that may occur as result of adhesions, but I do not believe as a rule after effects are anything but slight, and I doubt if a second operation is ever necessary, except occasionally in drainage cases.

I remember Prof. Keen's remarks very distinctly. I think his remarks were made to offset some of the radical statements made by a few physicians on the other side. I have every confidence that he could operate a hundred cases in the quiescent period without a single death.

There is no objection to letting the patient out of the hospital in ten days if you get a primary union. There is no danger of hernia. The period of infection is past, the skin incision united. The shock is not any greater than anesthetizing and reducing a fracture of arm or leg, and yet such patients are allowed to leave the office or hospital at once.

Next upon the program was a paper by Dr. Charles G. Foote upon "Diagnosis of Tubercular Disease of Bone."

Dr. Foote's paper will appear in the September issue of the GAZETTE.

*Dr. Quirk:* At a recent meeting I referred to a method of early diagnosing tubercular disease of bone, and that was by the agglutinating properties of the blood in a tubercular patient. It is similar to the process for the determination of typhoid and might be used as a method of discriminating in the early stages of tubercular disease in connection with the physical signs.

*Dr. Bunts:* In regard to the differential diagnosis of tubercular disease of the bone, it is far more difficult than if we had to differentiate simply from acute osteomyelitis, but when we have a mixed infection then the diagnosis becomes exceedingly difficult. I think, also, that tubercular disease of the bone is often confused with sarcoma of the bone.

I have seen this mistake made several times and have myself incised a small sarcoma under the impression that it was a tubercular disease near or communicating with the knee joint. A microscope examination showed it to be a sarcoma, and its very rapid growth necessitated a hip joint amputation. No local recurrence took place, but the patient died about eight months later from a presumably metastatic growth in the chest. No autopsy was allowed.

Dr. N. Stone Scott was the next upon the program, but the hour being late, he begged to have the reading of his paper postponed until the next meeting. On motion this request was granted, with the proviso that his paper upon "Subjective Symptoms of Pyloric Stenosis" should be the first one upon the program of the regular meeting.

Adjourned at 10 :05 p. m.

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## Correspondence.

ST. LOUIS, MO., July 6, 1900.

*Cleveland Medical Gazette, Cleveland, O.:*

GENTLEMEN:—Lest our announcements in the June number of the *Medical Mirror* regarding the prizes we have been pleased to offer for theses on tuberculosis, have escaped your notice, we submit the following condensed statements and will appreciate highly any mention of which you may deem them worthy.

The *Medical Mirror*, of St. Louis, offers \$1,000.00 in prizes to be distributed as follows: \$500, \$200, \$100, and four prizes of \$50 each. The following prominent gentlemen have accepted appointment on the committee on awards: Dr. Wm. Osler, Baltimore, Md.; Dr. George F. Butler, Chicago, Ill.; Dr. A. R. Kiefer, St. Louis, Mo.; Dr. C. Lester Hall, Kansas City, Mo.; Dr. H. R. Hall, St. Louis, Mo.; Dr. Lewis E. Lemen, Denver, Col.; Dr. Joseph M. Mathews, Louisville, Ky.; Dr. W. W. Grant, Denver, Col.; Dr. Thomas Hunt Stucky, Louisville, Ky.; Dr. Hugo Summa, St. Louis, Mo.; Dr. Walter Wyman, Washington,

D. C. Entries close October 1, 1900, and the award is made January 1, 1901, giving the contestants three months in which to prepare their papers and to include clinical reports. The points for consideration in each paper, with a percentage attached, will be as follows: General considerations of the subject, 10; pathology, bacteriology and diagnosis, 20; clinical reports, 20; prognosis and treatment, 35; conclusions with resume, 15.

We hope to develop from this discussion the fact that much more can be done for our tubercular patients than the average practitioner believes, and we are aiming to elicit all facts that may be of value in the treatment of this disease.

Feeling that your co-operation can be depended upon, we are,

Very truly yours,

MEDICAL MIRROR.

J. W. C.

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BUFFALO, N. Y., July 3d, 1900.

*Editor Cleveland Medical Gazette, Cleveland, O.:*

DEAR SIR:—The Pan-American Exposition has seen fit to entrust the care of the department of Ethnology and Archaeology to a practicing physician. I should be very glad if you would allow me to reach your readers with the following request for assistance.

Many members of the medical profession are interested in the study of American Ethnology and Archaeology, and not a few have valuable collections of Indian relics and skeletons from Indian graves. Those not directly interested in this study are so circumstanced as to be aware of the hobbies of their neighbors and could doubtless furnish the address of collectors. I should be greatly obliged for information and for the loan of collections for the use of this department of the Exposition. Exhibits which represent study in some special line of American Ethnology and Archaeology will be particularly suitable.

Very truly yours,

A. L. BENEDICT, M. D.

Superintendent of Ethnology and Archaeology.

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LOUISVILLE, KY., July 6, 1900.

DEAR DOCTOR: Your attention is called to the twenty-sixth annual meeting of the Mississippi Valley Medical Association, which will be held at Ashville, N. C., Tuesday, Wednesday, and Thursday. October 9, 10, 11, next, under the Presidency of Dr.



Harold N. Moyer, of Chicago. At a meeting of the Executive Committee held at Atlantic City, June 6th, the following were chosen to deliver the annual addresses: Dr. I. N. Love, of St. Louis, the address in Medicine; Dr. C. A. Wheaton, of St. Paul, Minn., the address in Surgery. The mere mention of these names is guarantee sufficient that the Association will hear only the best.

Negotiations are in progress by which the members of the Association may obtain a one-fare rate for the round trip for this meeting. The Southeastern Passenger Association has already granted this rate, and it is believed the Western and Central Passenger Association will concur. Due notice of this will be sent later.

It is earnestly requested that those desiring to read papers will send their titles to the Secretary within the next thirty days. It is also requested that a brief synopsis of the paper of not less than twenty-five words accompany the title.

The Association will not be divided into sections at this meeting. The headquarters will be at the Battery Park Hotel, at which place the sessions will be held.

Those who will read papers are requested to hand them to the Secretary—typewritten—for use of the Publication Committee.

Fraternally yours,

HENRY E. SEELEY, Secretary.

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## **Notes and Comments.**

**Dr. J. E. Adams** has recently located at 380 Pearl street.

**Dr. F. C. Siffert**, of Canton, was in the city on the 27th July.

**Dr. Gilmore**, recently of Chicago, has located at 730 St. Clair street.

**Dr. A. M. Webster**, who has recently located at Lorain, was in the city on 24th July.

**Dr. William E. Wirt** was married to Miss Alma McMillan, a Cleveland lady, on 18th July.

**Dr. N. W. Price**, of 3425 Euclid avenue, was married on 5th June to Miss Harwood, of Toronto.

**Dr. W. F. Hribal** has located at 196 Beechwood street. He also has an office at 614 Ontario street.

**Dr. and Mrs. F. Oakley**, of Toronto, are visiting their son, Dr. A. F. Oakley, of 691 East Prospect St.

**Dr. C. F. Hoover** is to be married on the 9th of August. Dr. and Mrs. Hoover will spend six weeks in Scotland, on their wedding trip.

**Dr. Hunter Robb** will spend his vacation at Murray Bay, Quebec, and at the Adirondacks during August and until 15th September.

**Dr. B. O. Coates** had his left arm broken, just above the wrist, on 17th. The accident was caused by being thrown from a street car.

**Dr. John Perrier** left on the 20th July for a trip East to Halifax, N. S., Sidney, C. B., and other places. He will be absent about a month.

**Drs. Hoover, Robb and Wagner** have taken offices in the Rose Building. Dr. Wagner will move in in September and Drs. Hoover and Robb in October.

**Dr. and Mrs. D. S. Hanson**, their two daughters and the doctor's sister took a trip up the lakes and spent a couple of weeks at Mackinac Island during July.

**Dr. H. C. Crumrine** has terminated his service at the Cleveland General Hospital and has opened an office at 102 Handy street. Dr. Crumrine will assist Dr. Parker.

**Dr. Charles C. Stuart** left on the 17th for Edgewood, near Alexandria Bay, St. Lawrence river, to visit with his wife and child, who are the guests at Mrs. Hartzell's cottage.

**Dr. and Mrs. Edward A. Campbell** and daughters, Florence and Edith Campbell, left on Thursday to spend the remainder of the summer at Kennebunk port and Popham beach, on the coast of Maine.

**Dr. A. R. Cunningham**, of the class of 1900 of the Medical Department of the Western Reserve University, has received an appointment as resident physician on the staff of the New York Lying-In Hospital. Dr. Cunningham was one of the successful applicants among the seventeen who applied for the seven vacancies.

**The Cleveland General Hospital Staff** met on 12th July to transact business and elect officers. The following officers were

elected: President, Dr. J. F. Hobson; Vice-President, Dr. N. Stone Scott; Secretary, Dr. Edward S. Lauder; Drug Committee, Dr. J. B. McGee.

**The following graduates** of the class of 1900 of the Medical Department of the Western Reserve University, have secured positions in hospitals in Cleveland and elsewhere:

City Hospital.—Clinton H. Bell, J. R. Moore, Wm. H. Williams, Wm. L. Green.

Lakeside Hospital.—Wm. B. Chamberlain, John C. Darby, Wm. C. Gill, Geo. D. Henderson, Frederick M. Lynn, Edmund A. Weekes, C. D. Williams.

Charity Hospital.—LeRoy B. Eberhardt, Eugene O. Houck, Wm. H. Phillips, F. H. Suchy (now at St. Clair Hospital), Lincoln A. Wheelock.

St. Clair Hospital.—Howard C. Miller, F. H. Suchy (at Charity Hospital in autumn).

St. Alexis Hospital.—Joseph A. Dunn.

**The death of Geh. Rath. Prof. Dr. Willy Kuehne**, the eminent physiologist of the University of Heidelberg, Germany, occurred July 10th, 1900, after a protracted illness. Kuehne was famed for classical work along physiologic-chemic lines and in particular with reference to the digestive ferments and protein bodies. He had a peculiar and warm attraction for young medical chemists and always showed great consideration for worthy Americans and other foreigners.

Workers along medic-chemic lines keenly appreciate the loss which Germany especially sustains in the peculiarly recent demise of Hoppe-Seyler, Baumann, Drechsel, Ludwig, Carl Schmidt and Kuehne, together with Pasteur and Schuetzenberger of Paris, all within five years and all a grievous loss to medicine.

**Medical Hero of Transvaal War.** Surgeon-Captain R. A. Buntine has recently performed a valiant deed under Boer fire and is likely to receive the V. C. from the authorities. While on patrol duty the Natal Carabiniers were surprised by ambushed Boers and forced to retire, leaving a wounded trooper on the ground. Dr. Buntine with his servant rode back, dismounted, placed the wounded man on his horse, and then, in the midst of a sharp rifle practice, ran back to camp. All three arrived in safety.  
—*Medical News*.



**Lying on the Left Side.** The difficulty that most persons experience in lying on the left side is attributed by Jacobi to the lack of support of the heart by other organs in this position. Hence the heart becomes more flaccid and requires greater effort to empty itself, the respirations being correspondingly increased.

**The Pathognomonic Sign in Colles' Fracture.** Martin W. Ware, in the *Medical Record* for March 31, says that the silver-fork deformity is encountered in less than 10 per cent. of cases of fracture of the lower end of the radius. Consequently this sign is not of much use in the diagnosis of this injury.

In its place he mentions a sign which is always present, namely: the elevation of the styloid process of the radius.

Normally the ulner styloid is on a higher plane than the radial, which can be easily demonstrated by placing the forefinger and thumb on the two styloid processes and connecting them by an imaginary line.

In estimating this sign the normal wrist must always be taken in comparison.

**Imagination and Disease.** Illustration of a Well-Known Physiological Phenomenon. In "A Journalist's Note-Book" Frank F. Moore tells an amusing and significant story of the influence of imagination upon health. A young civil servant in India, feeling fagged from the excessive heat and from long hours of work, consulted the best doctor within reach. The doctor looked him over, sounded his heart and lungs, and then said gravely: "I will write you to-morrow."

The next day the young man received a letter telling him that his left lung was gone and his heart seriously affected, and advising him to lose no time in adjusting his business affairs. "Of course you may live for weeks," the letter said, "but you had best not leave important matters undecided."

Naturally the young official was dismayed by so dark a prognosis—nothing less than a death warrant. Within twenty-four hours he was having difficulty with his respiration and was seized with an acute pain in the region of the heart. He took to his bed with the feeling that he should never arise from it. During the night he became so much worse that his servant sent for the doctor.

"What on earth have you been doing to yourself?" demanded the doctor. "There were no indications of this sort when I saw you yesterday."

"It is my heart, I suppose," weakly answered the patient.

"Your heart!" repeated the doctor. "Yoru heart was all right yesterday."

"My lungs, then."

"What is the matter with you, man? You don't seem to have been drinking?"

"Your letter!" gasped the patient. "You said I had only a few weeks to live."

"Are you crazy?" said the doctor. "I wrote you to take a few weeks' vacation in the hills and you would be all right."

For reply the patient drew the letter from under the bed-clothes and gave it to the doctor.

"Heavens!" cried that gentleman, as he glanced at it. "This was meant for another man! My assistant misplaced the letters."

The young man at once sat up in bed and made a rapid recovery.

And what of the patient for whom the direful prognosis was intended? Delighted with the report that a sojourn in the hills would set him right, he started at once, and five years later was alive and in fair health.

**A Wealthy Pauper Patient.** One of the odd phases of human character brought to light in Bellevue hospital came to the attention of the authorities on July 6th, in the case of Susan Fallon, eighty-five years old, who was brought there as a charity patient from her squalid rooms in East Twenty-second street. The old woman was suffering from jaundice, was in rags and tatters, and having not a relative in the world to care whether she lived or died. The neighbors reported her case to the hospital. After she had been placed in a hospital cot, her clothing was searched according to the rules of the institution. Two bank books were found, one on the Seamen's Bank, showing a deposit of \$1,261.24, the other on the Bowery Bank, and showing a credit of \$921.75.

**At a Meeting of the Corps of Teachers** of the New York School of Clinical Medicine, held at the Academy of Medicine, June 21st, 1900, it was decided to wind up the affairs of the school and close it permanently. This action was taken in consequence of continuous interference of the lay Board of Trustees in its affairs. The Teaching Corps consisted of Drs. Simon Marx, Herman L. Collyer, Wm. M. Leszynsky, Wm. S. Gottheil, Ludwig Weiss, S. Henry Dessau, Louis Fisher, Marcus Kenyon.

**Echoes of the Fourth.** It is said that the Fourth of July just passed was more generally and generously observed than for many years. The weather was fine and prosperity favored a free expenditure of money. Seven millions of dollars, it is estimated, went up in the blaze and smoke and noise of fireworks. It was quite a Chinese affair. Fingers, hands, eyes and lives were freely sacrificed. In Philadelphia seven children in one group lost their lives while indulging in these Oriental orgies. At one east-side dispensary in New York 350 cases of burns and gunshot wounds were dressed on July 5th. Only two cases of tetanus have thus far been reported, but it will be surprising if the next few days do not add a score to this list. The almost daily showers, however, have kept the streets of the city unusually clean and the tetanus bacilli correspondingly scarce.

**Hygiene in the British Army.** Mr. Treeves tells us that Dr. Jameson says that the only way to deal with South Africa water is to boil it, strain it, filter it, and then throw it away. Colonel Baden-Powell, on the other hand, has a unique recipe for securing aseptic water (which is not aseptic) for wounds, as follows: "Take an ordinary native girl, tell her to go and get some lukewarm water and don't give her anything to get it in. She will go to the stream, kneel and fill her mouth and so bring the water; by the time she is back the water is lukewarm. You then tell her to squirt it as you direct into the wound, while you rinse it around with a feather." What does Lord Lister think of the asepsis of this method?

**Significance of a Small Induration in the Breast of a Woman over Thirty.** A. Marmaduke Shield says that the importance of the early recognition of cancer of the breast is not always appreciated. It should be known that the beginning of cancer of the breast is very insidious, and not attended by any great pain or discomfort. If a woman of the cancerous age gets an abiding patch of induration in the breast, however small or apparently insignificant, it is serious. In nine cases out of ten it will prove cancerous. If not cancerous, it will be inflammatory, or a small, deeply seated cyst with thick walls. Exploratory incision, to be followed, if necessary, by removal of the breast, is the right course. If all cancers and the neighboring lymphatic area were removed in the early stage, the results would be far better than they are.—*Clinical Jour.*, October 4, p. 380; *Med. Rev.*



**How to Stop Coughing.** The *Virginia Medical Semi-Monthly* correctly states that coughing is precisely like the scratching of a wound; so long as it is continued, the wound will not heal. Let a person, when tempted to cough, draw a long breath and hold it until it warms and soothes every air cell. The benefit will soon be apparent.

**Strychnine Causing Cerebral Hemorrhage.** The writer calls attention to the danger of giving strychnine to patients who have arrived at the degenerative age, and especially in all cases of cirrhotic Bright's disease, chronic gout and syphilis, or where a patient has thickened or tortuous blood-vessels, or even where there has been an hereditary tendency to apoplexy. He reports the case of a man aged sixty-four, with atheromatous vessels, who had been in the habit of taking the syrup of iron, quinine, and strychnine. A larger dose than usual was followed by a right-sided cerebral hemorrhage which proved fatal. The writer believes the hemorrhage to be due to the increased blood pressure caused by the strychnine.—Dr. Grant in *Medical Record*.

**Hot Fomentation.** A hot fomentation that will not require to be changed frequently can be made by dipping a flat section of sponge in hot water. Apply to the part, and upon the sponge place a hot water bag. If desired, the water in which the sponge is dipped may be medicated.—*Medical Dial.*

**When to Give Opium in Diarrhoea of Young Children.** It is contra-indicated (1) in the first stage of acute diarrhoea, before the intestinal canal has been cleared of decomposing matter; (2) when the passages are infrequent and of bad odor, (3) when there is a high temperature or cerebral symptoms are present; (4) when its use is followed by an elevation of temperature or the passages become more offensive. It is indicated (1) when the passages are frequent, with pain; (2) when the passages are large and watery; (3) in dysenteric diarrhoea, together with castor-oil or a saline; (4) in later stages with small, frequent food, and the bowels act as soon as food is taken into them.—*Crandall, N. C. Medical Journal*.

**To Remove the Odor of Iodoform.** Dr. Edwin Ricketts states, *Cincinnati Lancet-Clinic*, a teaspoonful of vinegar rubbed on the hands after thorough cleansing with soap and water, "does away promptly with the very disagreeable odor" of iodoform.—*Penn. Med. Jour.*

**George Ebers**, the Egyptologist, has discovered that many of the queer medical recipes found in old English and German books came from the ancient Egyptians. They were not known to the Greeks, but were spread from Salerno, the great medical school of the Middle Ages, to which they must have come through Coptic and Arabic translations.

**Limiting the Output of Doctors in Russia.** The Russian Government has grappled with the question of the overproduction of medical practitioners in a drastic manner peculiarly its own. By a recent decree of the Minister of Education the admission of first-year students by the several medical faculties throughout the empire is restricted to a fixed number. The University of Moscow is limited to 250, Kieff to 200, Charkow to 175, Dorpat to 150, Warsaw to 100, Tomsk to 120, and Kasan to 100. The total number of first-year medical students in the dominion of the Czar must, therefore, not exceed 1,095. This number does not include the students of the St. Petersburg Medico-Military Academy, which is allowed to admit 250 first-year students.—*British Medical Journal*.

**Incontinence of Urine.** According to the *Buffalo Medical Journal*, lycopodium has been used with success for this affection in children. Twenty drops of the tincture should be given three times a day, and this dose may be increased to 40 or 50 drops. It is, in some cases, more efficient than belladonna.

**To Keep the Hands Soft and White.** In these days of asepsis the hands of the physician, and especially of the surgeon, suffer greatly from frequent scrubblings and immersions in antiseptic solutions. A preparation that will keep the hands soft and white and that will not at the same time be inelegant to use is always in demand. The following formula will be found to be one of the very best ever proposed for the purpose:

R Ol. rosæ, 15 drops.  
Glycerin, 1 drachm.  
Spt. of myrciæ, 3 drachms.  
Ol. cajuput., 20 drops.

M. Apply at night before retiring, first washing the hands thoroughly in hot water. In cold weather this can also be applied to the hands before going out.—*California Medical Journal*.

## Counter-Irritants.

### Some Mediaeval Jokes.

There is a curious little work, the contents of which are said to have been collected by Hans Sachs, the Nuremberg cobbler and mastersinger, in 1517. This curious book was reprinted several times in the seventeenth and early part of the eighteenth century, but is now somewhat scarce. It was issued without place of publication or publisher's name, in small form without cover. The book pretends to have been prepared by Hans Sachs for his private use, that he might make merriment among his friends, when drinking, and they were tired of his songs. It does not contain any anecdotes. It is made up of a collection of riddles more or less good, some coarse and some profane; but the age was not squeamish.

Here are some of the conundrums:

Q. After Adam had eaten the forbidden fruit did he stand or sit down? A. Neither; he fell.

Q. Two shepherds were pasturing their flocks. Said one to the other, "Give me one of our sheep, then I shall have twice as many sheep as you." "Not so," replied the second herdsman; "give me one of yours, and then we shall have equal flocks." How many sheep had each? A. One had seven, the other five. If the first took a sheep out of the flock of the second, he had eight, the other four; if the contrary, each had six.

Q. What is four times six? A. 6,666.

Q. What does a goose do when standing on one leg? A. Holds up the other.

Q. When did carpenters first proclaim themselves to be intolerable dawdles? A. When building the Ark—they took a hundred years over it.

Q. Under what law are the soldiers? A. Can(n)on law.

Some of the riddles have survived in the jocular mouth to the present day. For instance, who does not know this? Q. What smells most in an apothecary shop? A. The nose. There is one conundrum which surprises us. The story was wont to be told by Bishop Wilberforce that he had asked a child in Sunday-school why the angels ascended and descended on Jacob's ladder, whereupon the child replied that they did so because they were moulting, and could not fly. But this appears in Hans Sach's book, and is evidently a very ancient joke indeed.



In this collection also appears the very heavy riddle, "Which is heaviest, a pound of lead or a pound of feathers?" which every one knows, but with an addition, which is an improvement. After the answer, "Each weighs a pound, and they are equal in weight," the questioner says further: "Not so; try in water. The pound of feathers will float, and the pound of lead will sink."

Q. How can you carry a jug of water in your hands on a broiling summer day, in the full blaze of the sun, so that the water shall not ~~get~~ hotter? A. Let the water be boiling when you fill the jug.

Q. How can a farmer prevent the mice from stealing his corn? A. By giving them his corn.

Q. A certain man left a penny by his will to be divided equally among his fifty relatives, each to have as much as the other, and each to be quite contented with what he got, and not envy any of the other legatees. How did the executor comply with this testamentary disposition? A. He bought a packet of fifty tin-tacks with the penny, and hammered one into the back of each of the legatees.—*Chamber's Journal*.

# THE Cleveland Medical Gazette

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SEPTEMBER, 1900.

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## Original Articles.

### CLINICAL LECTURE ON CATARACT.\*

BY D. B. SMITH, M. D.

Professor of Diseases of Eye, Ear and Throat, Cleveland College of Physicians and Surgeons.

I want to talk to you a little this morning on the subject of cataract. A cataract is an opacity of the crystalline lens, and we speak of it as either partial or complete. The diagnosis of cataract now that we have the ophthalmoscope is easily made. Before the discovery of the ophthalmoscope we were obliged to depend upon other tests for the diagnosis of cataract, some of which are these: One of the first symptoms of beginning cataract is a want of distinctness of vision for distant objects, which simulates near-sightedness, although it is not, and as the object comes nearer and nearer vision becomes more distinct and is less disturbed. This apparent myopia is caused by a swelling of the lens due to absorption from the aqueous and vitreous humors. Another symptom is the seeing of dark spots in front of the eye. These spots are fixed and are in certain localities in the lens. Where there are opacities there are dark spots, and this is more apparent when looking at a bright light. We used to use what is called the entopic test. Take a cardboard, make a small pin-hole and allow the patient to look through that pin-hole at a bright light, when the patient will see the opacity of his own lens caused by the shadows which fall upon his retina, and by comparing the opacity at one time with another he can determine the rapidity with which it develops. There was the catoptric test, which consisted in hold-

\* Delivered to the Graduating Class of the Cleveland College of Physicians and Surgeons, at the Cleveland General Hospital, 11th April 1900.

ing a lighted candle in front of the eye in a dark room and watching the reflection of the flame from the different structures of the eye. The reflection from the cornea will show the flame in its upright position; the reflection from the anterior capsule also shows the flame in its true position, while that from the posterior capsule in a normal eye shows the flame inverted. If you move the candle from side to side the first two flames move with the candle and the third moves in an opposite direction from the candle. This was used to determine the transparency of the crystalline lens. If the crystalline lens was opaque then only the first two flames would be visible—the third flame would not be seen, because we could get no reflection from the posterior capsule. If you drop into the eye a few drops of cocaine and dilate the pupil and then reflect light with the ophthalmoscope you see the opacities of the lens showing upon the red reflex which we get from the fundus of the eye. In this way we can determine the extent of the opacity and the portions of the lens which are opaque, and also whether it is one of partial or complete opacity of the lens.

Aside from the haziness of objects which we get in developing cataract, we often get double vision and multiple vision, according to the portions of the lens through which the light passes. Prismatic effects are also among the symptoms of cataract—a peculiar dazzling of the eye in a bright light.

Improvement of vision by shading the eye is also another peculiarity of cataract. A patient with cataract will hold the head down, while in other forms of blindness, as in glaucoma, the patient will hold the head up, or in blindness from many other causes where the optic apparatus or the nerve portion is at fault. They hold the head down so the pupil will dilate, because through a dilated pupil they get more distinct vision. As the cataract matures perception of light grows less and objects are seen less and less distinctly, until finally they are not seen at all in the direct line of vision, and only in peripheral vision are seen very indistinctly. Whenever cataract is present there ought to remain, if there is no complication with the cataract, good perception of light and also good projection of light. The patient ought to be able to tell exactly the direction from which that light comes; we call this projection of light. The patient should distinguish the degree of light—we call that perception of light. They should have not only good perception, but they should have good projection. In complete cataract it would be necessary to apply some



such test as this to know whether the patient would be benefited by an operation or not. They may have a detachment of the retina, they may have atrophy of the optic nerve, they may have inflammation of the retina or choroid, or there may be some difficulty farther back in the course of the optic nerve, or at the base of the brain which would render an operation useless.

We describe cataracts according to various conditions of the cataract and the methods of their development. A cataract is either cortical or nuclear, soft or hard—as to the degree of consistency. Cataracts are congenital, senile, and traumatic. Under the head of congenital cataracts we include the soft congenital—where there is complete opacity of the lens, and zonular cataract—when only the marginal part of the lens is opaque. We have capsular cataract, which is dependent upon the opacity of the anterior or posterior capsule, and we describe a pyramidal cataract where there is exudation on the capsule which is in the shape of a pyramid—which pushes out from the capsule; we describe a morgagnian cataract where the cataract is partly fluid and partly hard, the cortical substance becomes fluid and the nucleus remains hard. This occurs generally in older people, and seldom in middle age. The diagnosis of this form of cataract is the difference in color in the territory of the pupil which we get in different positions of the head. If the patient looks straight forward you may see only the fluid part of the lens; if the patient's head is directed at right angles to the body so that the nucleus drops down on the anterior capsule we may distinguish a different colored nucleus and cortical substance.

Then we have also a diabetic cataract which we recognize as a peculiar form of cataract. It is really only a soft cataract, but it is accompanied with diabetes. We have also traumatic cataracts, which are brought about by some injury to the eye, and under the head of traumatic cataracts we include not only those in which the lens itself is partly injured by cutting and puncturing, but we include also under traumatic cataracts those which develop after a time as the indirect result of an injury; for example, some blow upon the eye, face or head. This form of cataract is usually soft. We describe also a secondary cataract which comes on after operations for cataract and it may come after any of the operations for cataract with the exception of those operations which remove the lens and capsule entire. This secondary cataract is not true cataract in the sense that it is opacity of the crystalline lens. It is simply opacity of the posterior capsule of the lens. Those forms

of cataract which develop after fifty years of age are usually called senile—in contradistinction to the other varieties. They are usually hard, although not necessarily so. These varieties of cataracts should be recognized easily.

Cataracts have been called by a large number of other names, dependent upon their methods of growth or other peculiarities, which are entirely optional on the part of the one who describes them and not necessarily distinct forms of cataract. For example, if the cataract commences in the central part of the lens in the shape of straight lines it has been called central striated, while if it commences in the periphery of the lens it is called peripheral striated. There are quite a large number of names that may be given to cataracts which really only describe certain peculiarities of the cataract, and have nothing to do with the cataracts as distinct and separate species.

The cataract before operation should be mature, because a mature cataract separates more easily from the capsule in which it is held, and there is less liability of particles of the cortical substance being left behind. The rapidity with which cataracts mature is exceedingly variable. In one instance the cataract will mature in a few months and in another it will be many, many years. I have seen cataracts fifteen or twenty years and watched their progress and seen them gradually develop a little more and a little more, while at no time was there sufficient opacity to require operation, and many times I have seen patients die from other causes before the cataract came to sufficient maturity to warrant operation. Sometimes when one is tired waiting for a cataract to develop, and a great deal depends upon the early maturing of the cataract, surgeons have attempted certain operations to mature it. One of these is to take a fine needle and puncture, through the cornea, the anterior capsule of the lens in order to allow the lens to become opaque.

Another is to make an iridectomy and then introduce the spatula and press gently upon the anterior capsule, or to incise the cornea and without iridectomy pass through the incision a spatula and make gentle pressure upon the capsule of the lens. This assists in the maturing of the cataract, and occasionally may have the purpose of hastening the ripening of the cataract. Patients who are blind from cataract are very desirous of having their vision restored, and this is done only by means of an operation. There is a natural shrinking of a mature or over-mature crystalline lens which gives the patient a little better degree of

vision, and it is upon this condition that all those who are disposed to treat cataracts by absorption or by electricity or by internal remedies depend for their temporary success. In a patient who has been treated for perhaps a couple of months, the cataract may slightly shrink, and lead a man to believe that he is improving, and that brings others who are not benefited in the least. So upon this particular condition depends the success of those who are "quacks" on the removal of cataracts.

The first operation for cataract was made before the time of Celsus by reclining and couching the lens. This consisted in introducing into the eye a broad needle which was passed through the cornea or sclerotic so as to come in front of the lens, and then the lens was pressed downwards into the floor of the fundus. When the lens has been pushed into the bottom of the vitreous it must be held there for a little time in order to allow the vitreous to flow over it and then it is more liable to remain in its place; sometimes the lens will go back again. This was the first operation for cataract which is described in eye surgery.

The first record of entire removal of cataract was the operation of Jacques Daviel in 1745, and he describes his operation in these words:

"I open the anterior chamber with a curved needle and enlarge the wound with curved scissors. I introduce a small curette into the pupil, detach the cataract and remove it in small particles. The pupil remains clear, the patient suffers not the least accident and is cured in two weeks."

This was his own description of the operation and was the beginning of methods of extraction which are in vogue today.

In 1811 Gibson described the linear operation, which consisted in making a linear wound through the cornea from side to side and then cutting the capsule of lens with a *cystotome*, which is a sharp instrument of hook shape, and then by pressure upon the upper portion of the wound with a Daviel spoon the wound was pushed open from above and pressure was also made over the lower edge of the lens and the lens crowded out through this linear incision.

Richter and Beer about the same time described the flap extraction, which consisted in making an incision just in front of the sclero-corneal junction on the one side and passing through to the sclero-corneal junction on the other side, and then cutting out this section, making a large flap in the cornea, nearly one-half of the cornea being separated at its sclero-corneal border. Beer



devised a knife which cuts as a wedge by pushing, and ever since that time—about a hundred years—it has been called the Beer cataract knife.

The flap operation was also used largely by Prof. Jager, of Vienna, the grandson of Beer. After making the first incision through the cornea, a curved needle was drawn into the wound until it came to the territory of the pupil, and then the capsule was opened by crucial incisions in different directions, the lens pressed forward into the anterior chamber, and by manipulating above and below\* was gradually pressed out of the wound. This operation met with favor for a long time, but on account of the size of the wound and the ignorance of antiseptic treatment which prevailed in those days, many eyes were lost by suppuration. The flap necrosed and hence the operation fell into disrepute. Frequently the iris would prolapse and be caught in the wound, and it would be difficult to replace it.

Jacobson suggested that one make an incision and then make a small iridectomy through which the cataract could more easily pass. This operation was in favor for a number of years.

In 1865 Bowman and Von Graefe described the modified linear operation. This operation has ever since gone by the name of Graefe's modified linear operation. This operation consisted in passing at a point just behind the sclero-corneal junction, about the upper edge of the moderately dilated pupil, a narrow knife to an opposite point. The blade of the knife was then held in the direction of a plane which would pass through the center of the eye, so as to make the linear incision in the line of a great circle, which gives the longest distance between two points, on a sphere. By making it in the line of a great circle he got the largest linear incision possible at point of incision. He combined also the iridectomy as recommended by Jacobson. An incision was made, the iris was pulled out to one side and clipped, pulled upwards and clipped, and pulled to the other side and clipped, cutting the iris as close to the margin of the cornea as he could. The scissors were gently pressed down upon the sclerotic. The next step in the operation consisted in opening the anterior capsule, which was made by means of the cystotome as before. An incision was made in the upper edge of capsule parallel to the margin of the cataract and then the cystotome was passed downwards to a point as far as the lower margin of the pupil, making a crucial incision. The lens pressed forward into the territory of the pupil. Then by pressing backwards upon the lower portion

of the cornea the lens was tilted forward and the upper edge gradually pushed through the wound and pressed out. This operation for a long time was considered the very best cataract operation which could be made, and was at that time many steps in advance of any of the other operations.

Still later De Wecker made the two millimeter flap wound—that is, the distance between what would have been a linear wound and the highest point of the actual wound was two millimeters. This gave a small flap. With this he combined a small iridectomy. The wound was made at the apex of the cornea. The iris was pulled upwards and was so removed that there was a small iridectomy at the upper edge of the wound. Then the other steps of the operation were practically the same as those of Von Graefe.

Dr. Swanzy, of Dublin, has recommended a three millimeter flap, as his modification of this cataract operation. This has been received with great favor.

Liebreich makes the incision from very near the margin of the cornea on one side to the margin of the cornea on the other, just a little above the center of cornea, which gives a long linear wound for the exit of the cataract. Then he opens the anterior capsule and crowds, by pushing downwards, the lens into the territory of the pupil and through the wound. The operation in his hands has been very successful, but in the case of the majority, the difficulty in pressing out the lens and the danger of anterior synechia are drawbacks to the operation. The pressure required to dislocate the lens you can easily see would be greater than in any other of these operations, with the exception of the original Gibson linear.

Prof. Knapp, of New York, describes his operation. He enters the knife at the margin of the cornea, about one-twenty-fifth of an inch above the center of the cornea, then passes his narrow cataract knife through to a point directly opposite, and then without changing the blade of the knife, by means of one or two sawing motions backward and forward, the cornea is cut through and a small conjunctival flap is made. He raises up the conjunctiva a little as the knife strikes through the cornea. Then he goes in and makes first an incision in the upper part of the capsule by passing the point of the systotome underneath the iris and cuts through the anterior capsule, and then by making also a crucial incision the lens is vacated by pressure from below and above and is crowded out without an iridectomy. The

operation is a modification, as you can see, of the original flap, only that the flap is smaller. You have here in this chart his method of introducing the knife. The knife is introduced from side to side.

The choice of an operation will depend somewhat upon the nature of the cataract and the eye of the patient, one operator preferring one, and another another, according to the skill with which he has been enabled to use the one or the other. As a rule soft cataracts can be removed without an iridectomy with very little difficulty. In hard cataracts, usually, some one of the operations which are made with iridectomy is preferable. In congenital cataracts the recuperative power of a child is great and absorption goes on rapidly, so that in most such cases we simply cut up the lens thoroughly by means of a fine cutting needle. This operation is called discission. The knife is passed through the cornea at some point not directly in the axis of vision, but a little to one side, the needle is then passed through the capsule and the lens is cut up in various directions pretty thoroughly so as to allow it to absorb rapidly, through the action of aqueous humor. The more rapidly the lens absorbs the clearer will be the pupil. During the process of absorption the pupil must be kept well dilated with atropin. This operation answers very well in cases of soft cataracts occurring before the age of twenty, or in exceptional cases a few years later. It takes generally from six weeks to three months for the cataract to absorb. In exceptional cases it is necessary to make a second operation. In zonular cataracts it is usually only necessary to make an iridectomy. In traumatic cataracts, where we have soft cataracts develop as a direct result of an injury, it is oftentimes desirable to relieve the pressure which is produced by the rapidly swelling lens, and in such cases you may either remove the lens by means of the linear method, or if the injury is quite recent, by introducing the cystotome, breaking up the anterior capsule, and pressing out the lens through existing wound the same as you would in the linear operation for soft cataract, pressing out as much of the lens as possible. The more it is pressed out the less inflammation you will have and the less difficulty in the process of healing. Sometimes, varying from a few days to two or three weeks, you will find the lens very much swollen, then it is desirable to make a linear wound and remove as much of the lens as possible. Sometimes we simply cut up the lens thoroughly. When the lens is well cut up and lies mostly in the anterior chamber and is surrounded by aqueous humor it



absorbs quite rapidly, and the irritation of the iris by pressure from in front is less than from behind. This operation assists very much in the after-treatment of cases of injury to the eye, causing traumatic cataract.

Various methods of operation have been made by surgeons in an effort to find something new, or for some benefit which may be derived therefrom. Japa used to make an incision through the sclerotic into the vitreous, and by means of a pair of forceps, passing one arm in front of the lens and the other behind it, pull the lens out through this sclerotic opening.

A surgeon of Venice made a linear incision and then with knee-scissors cut the cataract in two, removing the cataract in halves. Prof. Jones, of Glasgow, instead of making his dissections through the cornea generally made his incision through the sclerotic and cut open the posterior capsule instead of the anterior, saying that he had found that the lens absorbed more rapidly if the opening was in contact with the vitreous than when it was in contact with the aqueous humor.

Waldow recommended the scoop operation, in which he went in with a scoop, which had a little arm to it; this was passed in—after making the modified linear wound—behind the lens and then the lens was allowed to fall into this scoop and then it was withdrawn with its capsule.

Pagenstecher recommended the removal of the lens with its capsule, pressing over the lens until the ligament was broken and the lens dislocated with its capsule. Probably the three operations for senile cataract which are most successful and give the best results are the linear of Von Graefe, the three millimeter flap of Swanzy, and the operation of Prof. Knapp. An operation which can be made without iridectomy gives you the most perfect looking eye afterwards when the pupil remains round and unbroken, but you can easily see that it requires more pressure to remove the lens without iridectomy. After the skillful operation comes the next step, which consists in the dressing of the wound. After the lens has been removed one has to be very careful to see that no particles of lens are allowed to remain in the corneal wound. We judge as to whether the iris has been caught in the wound by the position of the iris in its normal plane and where the cut edges of the iris lie in straight lines from the pupil to the periphery we know that the iris is not caught. But if either side is caught we will notice a dark point showing between the edges of the wound. We then gently press behind so as to allow the

iris to drop back of itself or we lift up the edge of the cornea and then we can gently pass a probe and gradually work the iris back out of the edge of the wound until we find the cut edges of the iris lie in the same plane or, if no iridectomy was made, until the pupil is round. When the pupil is perfectly round we know that the iris is not caught in the wound. We then dip a bit of aseptic gauze in quite warm water and wipe carefully the edge of the wound until it is thoroughly clean. Then place a pledget of cotton which is aseptic, and over that a dark bandage, and over the dark bandage, if you wish to be still more secure, you can apply some kind of a shield which will prevent the patient from disturbing the eye. Generally if there is no pain, and no discomfort except that which occurs in the first few hours after the operation, we take off the bandage and look at the eye the next day, compelling the patient to keep the eye closed. We occasionally allow it to remain two or three days without removing or disturbing it. The less the wound is disturbed in the first four or five days the better. Some surgeons recommend that a drop of atropine be dropped into the eye about the fourth day. Prof. Jaeger used to allow eyes to go eight days without being disturbed—if there were no untoward symptoms.

Soft foods only are allowed for the first three days. There need be no restriction as to the kinds of food, but only as to consistency. I much prefer to have the patient remain in bed the first few days.

If there is pain lasting more than a few hours we give an anodyne. A four per cent. solution of cocaine is dropped into the eye four or five times at intervals of three to five minutes before any of the cataract operations. This renders the operation practically painless, while the freedom from pain enables the patient to hold perfectly still during all the steps of the operation. After four weeks the eye should be properly fitted with cataract glasses. The patient can begin to use the eye, gradually increasing the use, as soon as properly fitted.

The success attending the operation is excellent, and with improved methods of operating and careful antiseptic precautions it is very seldom that the result is not satisfactory.

## INTUBATION AND ANTITOXIN.\*

BY H. H. JACOBS, M. D., AKRON, O.

It is not my object in bringing up this subject, to advance any original ideas, but to render the old more prominent and to add my testimony to that already tabulated.

As you all know, it is by the aggregation of hundreds of cases, far more than any one individual could possibly fall in with, that the truth or fallacy of a given proposition is determined; that the value or worthlessness of a certain procedure is insured. By the hundreds of favorable cases of intubation that are on record and by the almost unanimous expressions of reliance upon this procedure, we have grown to look upon this operation as of a certain fixed and positive value.

Nevertheless, we find daily instances of deaths by suffocation from diphtheritic croup in which the operation has not been made, and frequently encounter physicians who either have never heard of this procedure, or have never read nor experienced enough of its benefits, to request that it be done.

It has been my own experience that in many cases the parents have been the first to mention or demand intubation, for the relief of impending suffocation. While my cases are not great in number, still they embrace practically all the operative cases in a district of 50,000 individuals, from January, 1894, to March, 1900. The lessons they teach parallel those of the hundreds of other operations in the many districts of this and other countries. Looking over these cases in order, both before and after the establishment of the antitoxic method of treatment, we find the following: Total number of cases 83, with 36 deaths and 47 recoveries, or 56 per cent. of recoveries. Cases treated without antitoxin 56, with 29 deaths and 27 recoveries, or 48 per cent. Cases intubated and in which antitoxin was used 27, with 20 recoveries and 7 deaths, being 74 per cent. of recoveries, which is easily seen to be a decided improvement upon the list without the serum treatment.

Although many observers are still unwilling to concede the benefit of antitoxic treatment of diphtheria, believing the variations in mortality due to differences in the potency of the disease at different times and in different places; still the laryngeal form of diphtheria has constantly and uniformly carried such a high rate of death that when we find a decided lessening in the mortality of this form it would seem hard to find any logical construction for it, except in the effect of the antitoxin.

\*Read before the Ohio State Pediatric Society, Columbus, May 9, 1900.



The initial dose varies from 500 to 6000 units, the amounts being larger than in other forms of the disease, the idea evidently being to get the disease quickly under control in order to lessen the danger of suffocation by the extension of membrane beyond the reach of mechanical aid.

It is undoubtedly true that in cases of croup where the larynx only is involved, the mixed infection is not so likely to occur, and hence we find good results after the administration of antitoxin even late in the disease, while in ordinary pharyngeal and nasal cases the mortality quite uniformly increases in direct proportion to the tardiness in giving the serum.

Another striking index to the value of antitoxin is the large number of cases of croup recovering without mechanical aid.

Before the use of this remedy it was the common experience that these cases would die without intubation and seldom was a child seen to be suffering from membranous croup that did not require intubation.

The writer's experience has also been that, although occasionally a child must wear the tube a week, the majority of cases may dispense with such help by the third day and many by the second, which is a great improvement upon the earlier days, when ten days and two weeks were all too common.

It is well to intubate your cases before cyanosis becomes constant, as by that time much exhaustion has taken place, for where is the labor, both physical and mental, in any way comparable to these terrible efforts to get sufficient air.

How soon the sufferer begins to complain of pain in the abdomen through the tiring of the accessory muscles. Intubate him then if you have not already done so.

After these frequent references to antitoxin it would seem quite pertinent to ask: What is this new agency? What its general make-up and how does it do its work? And right here is where we tread upon virgin soil, for although many explorers have visited and searched this territory, their findings have been few and hypothetical.

Serum therapy depends upon the observed fact that animals and individuals are either naturally immune, or can acquire immunity from poisons. This has led to a number of interesting theories as to the method by which this is brought about. The exhaustion method has for its basis the idea that the germs of disease consume all the food necessary to their existence and then perish for lack of proper nourishment. This theory became un-

tenable when the fact was discovered that an animal could be rendered immune by injections of the products of the same bacterial life. This fact led to the thought that probably the products of bacterial action were retained (retention theory) until they reached a point where the life of the germ was itself destroyed. This theory failed to explain the discrepancy between the rapid elimination of these poisons and the comparatively lengthy period of immunity.

Over the old theory of phagocytosis a prolonged warfare has been waged, but recent observers think it highly improbable that virulent germs, at the time of activity, can be destroyed by leucocytes.

The most promising of the later hypotheses is the one advanced by Erlich and called Erlich's side chain theory. The protein molecule, as we are assured, is extremely complex and is represented by giant molecules, somewhat fashioned after the solar system. The central part being represented by atoms closely bound together and joined less closely to more peripheral ones, called radicals. When these radicals are themselves complex, they are called side chains.

The theory is that when the poisons produced by the germs are brought in contact with these molecules, found within the cells, they unite with these side chains and are replaced by other side chains formed from the surplus nutriment stored up. Nature, stimulated by this effort to destroy her work puts forth renewed efforts and produces more side chains than can be utilized and these escaping into the general circulation form antitoxin. This theory would then explain natural immunity by supposing there were no side chains which would unite with the poisons. Acquired immunity by the manufacture of side chains to meet all demands, that is to replace the injured by the sound without delay.

Passive immunity, which has given the greatest impetus to serum therapy, would thus mean the rapid introduction of side chains, contained in the antitoxin, to make good the ravages of the bacterial poisons. This interesting theory would also explain the definite relation between a disease and its antitoxin.

Erlich's theory is more elaborately explained in an article by Dr. Dunham, of New York, in the *Journal of the American Medical Association* for April 14th, 1900. Adapting this theory to our needs we would then say that diphtheria antitoxin was serum containing numerous side chains produced in the cells of the horse, due to the stimulus of the artificially introduced poison of the

disease and acts in the individual by replacing the side chains rendered useless by the poisons of the Klebs-Loeffler bacillus.

While these different theories are interesting, they are also valuable in forming some working basis upon which, perhaps, some substantial structure may ultimately be reared. Perhaps the opinion of the profession in general could but be voiced by the statement that perhaps antitoxin acts as a powerful stimulus to the reconstructive functions of the body, whereby waste is stopped and repair quickly begun.

## NOTES ON THE ENEMATA EMPLOYED AFTER ABDOMINAL SECTIONS.

BY HUNTER ROBB, M. D.

Professor of Gynæcology, Western Reserve University; Gynæcologist-in-Chief to Lakeside Hospital, Cleveland, O.

For the thirst which is sometimes so distressing after an abdominal section, an enema consisting of 500 cc. (one pint) of tepid water may be slowly administered, being repeated if necessary.

Nutritive enemata are often employed at intervals of three or four hours. They should not be given more frequently than this for fear of rendering the rectum intolerant of them. The enemata should consist of milk with whisky or brandy, together with white of egg and a little common table salt. The following proportions make a good combination and may be given by means of a hard rubber syringe or through a rectal tube:

R Peptonized milk, 30 cc. (3i)  
 Whiskey, 30 cc. (3i)  
 The whites of two eggs  
 Common table salt, 1.5 (grs. xxiv)

The rectum should be thoroughly irrigated every morning with warm physiological salt solution which will keep it clean, so that the nutritive enemata will be better absorbed.

For opening the bowels a high enema consisting of 500 cc. (one pint) of soap-suds in warm water should be given. The rectal tube having been introduced well up into the rectum, the mixture of soap-suds and water is poured into a glass funnel attached to the external end and allowed to run slowly into the bowel. Sometimes a litre can be introduced in this way. If the enema does not prove effectual, it may be repeated after three or four hours, or we may substitute one consisting of warm water, oil, turpentine, in the following proportions:



- R Plain warm water, 500 cc. (oj)  
 Olive oil, 60 cc. (℥ii)  
 Turpentine, from two teaspoonfuls to a tablespoonful.

This may be repeated once or twice at intervals of two or three hours, but generally the first enema is followed by a satisfactory evacuation of the bowels. If preferred, from 120 to 180 cc. (4 to 6 oz.) of warm olive oil or glycerine may be first injected in order to soften any fecal matter that is in the rectum, an enema of soap suds and warm water being given an hour or so later. Occasionally the addition of an ounce of epsom salts to a pint of warm soap-suds and water will prove effectual when other enemata have failed.

In a series of 114 consecutive, unselected, abdominal sections without a death one or more of the above enemata were employed as a routine practice.

## THE DIAGNOSIS OF TUBERCULAR DISEASE OF BONE.\*

BY CHARLES G. FOOTE, M. D., CLEVELAND.

Assistant to the Chair of Surgery in the Cleveland College of  
 Physicians and Surgeons.

Acute tuberculosis of bone is comparatively rare. It usually occurs in the course of a general milliary tuberculosis, or as a secondary infection of the diaphysis of the long bone from an epiphyseal focus. In these cases the diagnosis is usually easy.

By far the most common form of the disease which we meet with is the chronic tubercular osteomyelitis. In fact about 95 per cent. of the chronic affections of bone may be classified under this head. It is essentially a disease of early life as most tubercular affections are. It is safe to say that almost all affections of the long bones, especially when located in the epiphyses, and occurring in early life, are tubercular. If abscess is present the diagnosis is positive, for there is only one other condition which might produce it,—actinomycosis.

The family history in these cases is frequently tubercular, and should always be inquired into in every case of bone disease.

The subjective symptoms are: 1. Pain. This is present in all degrees of severity, from a mere tired, uncomfortable feeling, following prolonged use of limb, to the severe excruciating pain resulting from the destruction of the subarticular layer of bone, and involvement of the joint. In children, restlessness, and the

\*Presented at the Cuyahoga County Medical Society on 5th July, 1900

so-called "night-cries" frequently occur. As a rule, however, especially in the early stages, the pain is not severe, the function of the limb not being markedly interfered with, the only discomfort being an "aching" or disinclination to use the limb. With the infection of the periosteum and formation of granulation tissue, resulting later in abscess, the amount of pain is much increased, or if the joint become involved, it usually becomes severe. The pain in the early stages is very often referred, as instanced by pain in the knee-joint, in diseases of the neck or head of the femur.\*

2. Tenderness. This symptom Dr. Senn considers of great diagnostic importance, especially in the early stages. He says, "the existence of an area of tenderness over a point corresponding to a tubercular focus in the interior of a bone is one of the surest indications of the existence of osteotuberculosis." This symptom can be elicited by pressure with the thumb or finger over the epiphysis of the bone. It is due to the presence of a circumscribed periostitis, situated above the tubercular focus.

3. Loss of function. This symptom should be considered under the head of tubercular arthritis, as it is unimportant in the early stage of tubercular osteitis.

The objective symptoms are:

1. Atrophy. This is usually present early, though in a slight degree, and is probably due to reflex causes. Vulpian was the first to bring forward the theory that the atrophy is due to irritation of the terminal filaments of the articular nerves, which is reflected the centers of the muscular nerves. That in some cases, the atrophy is direct is shown by its resulting from a neuritis involving both the articular and muscular branches of the same nerve, and from the fact that the atrophy is more or less permanent, even after the tubercular process has been cured.

2. Swelling. This symptom is usually not present in the early stage, and does not occur until the joint or periosteum becomes affected. There is usually no enlargement of the bone itself in cases of tubercular osteomyelitis, except in the condition known as spina ventosa, or in an extensive diaphyseal infection of the bone.

3. Changes in the color of the skin. With the occurrence of much swelling, the skin becomes very pale and is traversed by large blue veins. In the latter stages, when abscess formation occurs and the skin becomes involved, it has a purple or livid hue.

4. Abscess. Sooner or later, unless resolution occurs, the products of the inflammation undergo caseation and liquifaction, resulting in the formation of an abscess, which, sooner or later, finds its way into the joint or through the periosteum, burrowing in the direction of the least resistance until it opens through the skin, resulting in the formation of one or more sinuses. This is known as a cold abscess. It is usually slow in forming, and the symptoms of inflammation are not marked, whereas in those cases in which there is a mixed infection the local and constitutional signs are distinct.

5. Sequestration. As a result of the inflammation and disturbance of circulation, the formation of sequestra of greater or less size takes place. This can be demonstrated by the probe, or when of small size they are frequently seen in the discharge, which is of a peculiar, thin sanious character.

6. Rise of temperature. By carefully taking the temperature at frequent intervals, a rise of only perhaps one-half degree may be detected, especially towards evening, and is decidedly significant of tubercular trouble.

7. Anemia, emaciation, asthenia and hectic are not usually marked until we get a mixed infection. Then these symptoms become very pronounced.

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## TWO CASES OF MASTOIDITIS.

W. E. SHACKLETON, M. D., CLEVELAND.

Rhinologist and Laryngologist to St. Alexis Hospital.

B. P., age 21, American, plumber, was first seen Oct. 12, 1899. He stated that there had been a purulent discharge from his right ear for seven years. Two years ago the discharge nearly ceased and the diminution in quantity was immediately followed by severe pain in the ear and over that side of head, his temperature had risen and his physician had advised operation, but the advice was not followed. In a few days the ear again discharged freely, the pain was relieved, the temperature subsided and he was caused no serious inconvenience until one week ago, at which time the discharge again became scanty and very foul in odor. During the past week the temperature has fluctuated between 100 F. and 105 F., though the pulse has been little accelerated, seldom exceeding 80 per minute. Two days ago he had a distinct rigor and since has at times complained of feeling chilly. The pain in the ear and side of the head has not been constant, but at



times so severe as to require narcotics for its relief. At this time his temperature is 101.4, pulse 65, skin clammy, mentality dull, and in the erect posture he complains of nausea.

Examination of the ear revealed a small quantity of very fetid pus lying within the middle ear, the membrana tympani having been completely destroyed by the long continued suppurative process. Deeply situated the upper wall was slightly bulged, reddened and somewhat tender. There was no swelling over the mastoid process, neither could any tenderness be elicited by pressure, that could not be produced in the same degree in the healthy side by an equal amount of pressure.

The eyes were examined, and while not marked, a slight papillitis was thought to exist. The vision was not impaired. No palsy of extraocular muscles was present, and the pupils reacted to light and in accommodation. His condition remained practically unchanged until three or four hours before consent could be obtained to operate, when there was sudden severe pain in the affected side of the head and a rise in temperature from 101.2 to 103.6, the pulse rate remaining the same, 80. He rapidly became comatos, and operation now offered very little if any hope of recovery.

The mastoid antrum was opened and found to contain pus. After it had been emptied pus could be seen forcing its way through from above, and after enlarging the opening through the necrotic area of the tegmen tympani, several drams of pus escaped. The pulse, which had up to this time remained slow, now, upon the relief of pressure, became rapid and continued so until death 18 hours later. Unfortunately autopsy was not permitted, but it is thought that the history leaves little doubt as to the diagnosis, of purulent meningitis resulting from mastoiditis.

No. 2. W. G., 21, American, student, first seen March 1. He was in the third week of a typical attack of typhoid fever, and, therefore, the temperature and pulse will be of little aid in diagnosis. For two days he had been suffering from severe ear-ache and complained of pain and tenderness over the mastoid process. The ear drum was reddened and bulging and ruptured from the slight manipulation during the examination, allowing a bloody serum to escape into the external canal. Cultures were prepared from this fluid in the hope of finding typhoid bacilli, but none could be determined. He was more comfortable in a few hours time and operative interference deemed unnecessary. A profuse purulent otorrhea persisted for two weeks, which

gradually subsided, though a scanty discharge was present until May 1. The patient left the hospital for his home March 26 and was comparatively comfortable until April 19, when he again complained of pain and tenderness over the mastoid. The discharge had become slightly more profuse but was not of an offensive odor. The upper posterior wall of the external auditory canal was bulging so that but a very limited portion of the drum could be seen. The pain and tenderness over mastoid increased until April 26, when it was thought inadvisable to delay operation any longer. By this time there was a beginning edema back of and above the ear, and it was thought possible that perforation externally had taken place. This was not true, however, and no pus was found until the antrum had been opened. The quantity and flow with which the pus escaped justifies belief that the abscess was not limited by a bony wall and that already perforation had taken place internally, and the pus was occupying a not less dangerous position than the mastoid antrum. Relief from pain was immediate. Temperature dropped from  $102^{\circ}$  to normal. Convalescence rapid, the patient leaving the hospital on the fifth day.

A point to which I wish to give prominence is that swelling is not a safe indication for operation, for it may not occur at all in the chronic cases, and when present in acute cases it may not be until perforation of the cranial cavity has already taken place.

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## FORMALIN AND SOME OF ITS USES IN OPHTHALMOLOGY.

BY EDWARD S. LAUDER, M. D., C. M.

Assistant to the Chair of Ophthalmology, Cleveland College of Physicians and Surgeons; Ophthalmic Surgeon to the Out-Patient Department of the Cleveland General Hospital.

Formalin is the name of a 40 per cent. solution of formaldehyde gas in water. It is a colorless, volatile fluid, non-poisonous, of a pungent odor, and is miscible with water in all proportions. It is superior, in its germicidal action, to corrosive sublimate in solutions of a strength which can be well tolerated. When used pure it is an escharotic, but when in suitable dilution it is one of the most powerful antiseptics known. In fact, it is said to be the most powerful non-toxic antiseptic and bactericide at our disposal. Its value in this line may be more evident when we

consider that when used in a solution as weak as 1 to 100,000 it prevents the development of bacteria, and a solution of a strength of 1 to 75,000 is germicidal.

Its powerful bactericidal properties were pointed out by Loew in 1886, and further work was done upon the compound by Aronson, Berlioz, and by Trillat of the Pasteur Institute. The observations of Trillat were published in 1891. In 1894 Pattevin found that when Formalin was added to cultures of bacteria their growth was arrested. Cohn observed that Formalin had the power of killing bacteria both in the vegetative and spore stage—an observation confirmed by Alleger and others.

Formalin is a safer agent, by far, than corrosive sublimate, because it is not actively poisonous.

In Ophthalmology the strength of the solution which is preferable for general antiseptic use is 1 to 2,000. This strength is very useful in muco-purulent and follicular inflammations of the conjunctiva. For purulent conjunctivitis (ophthalmia neonatorum, etc.), a stronger solution may be used at first until the amount of discharge begins to decrease. In blennorrhœa of the lachrymal sac the use of Formalin has proven more satisfactory in my hands than has the use of Silver Nitrate solution. In both purulent conjunctivitis, except for the primary application, and blennorrhœa of the lachrymal sac I have for some time used Formalin in preference to Silver Nitrate. In cases of infected ulcerations or abrasions of the cornea the wound may be touched once a day with a solution as strong as 1 to 500 or 1 to 200.

All solutions of a strength under 1 to 4,000 cause smarting, but this is less intense and of short duration as compared to that caused by Silver Nitrate. In a solution of 1 to 2,000 or 1 to 3,000 Formalin is used to disinfect the skin of the lids and the eye-lashes prior to operation. For cleansing the conjunctiva prior to operation a solution of 1 to 4,000 is preferable.

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## Abstracts and Extracts.

Dr. Chas. G. Kerley, in a paper in the *Archives of Pediatrics*, on drug values in the management of 752 cases of whooping cough, states that antipyrine gave the best results, the bromides taking the second place. The two drugs given together proved more effective than either given separately. In a child eight months old he gives one-half grain antipyrine and two grains bromide of soda every two hours; at 15 months, one grain antipyrine



and  $2\frac{1}{2}$  grains of bromide of soda. Belladonna, even when pushed to its physiological effects, was not beneficial. He summarizes his paper as follows: We have learned

1st. That every case of whooping cough may be ameliorated either by modifying the severity or by diminishing the number of paroxysms. In many cases both the severity and number of the paroxysms may be favorably influenced.

2d. That remedies, sedative in character, with fresh air furnish the best results.

3d. That if a remedy is to be of service its beneficial effects will be noticed within twenty-four hours, always within forty-eight.

4th. That the best results are obtained when the antipyrin and bromid are commenced at the height of the paroxysmal stage, and then pushed.

5th. That these remedies being sedative in character, the effect may be lost in a prolonged case, requiring a change of treatment.

6th. That children may have whooping cough and never whoop.

133 West Eighty-third Street.

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In a thorough up-to-date discussion of the subject of appendicitis in the *Medical Record*, Dr. Jos. Weiner summarizes his views as follows:

1. Not every case of appendicitis should be operated on.
2. After a first mild attack, try regulation of diet and salines.
3. After first severe attack remove the appendix.
4. After two or more even mild attacks, operate.
5. In an acute attack (1) do not give opium or morphine. (2) Operate during an attack, (a) if a chill manifests itself; (b) if the pain is severe enough to require morphine; (c) if the pulse is very small, or rapid, or irregular; (d) if there is persistent vomiting; (e) if there is persistent rigidity of the abdominal wall; (f) if an abscess can be felt; (g) if the general condition makes it imperative; (h) if in doubt.

But it must not be supposed that every case comes under one of these headings, although the great majority of them will be found to do so.

In conclusion, I would say that I have endeavored honestly to outline what I believe to be the best plan of treatment in the

most important abdominal disease we meet with in this country. I have seen many patients get over a primary attack; I have seen many recover from a second and third attack. I have seen cases free from attacks for years, and then succumb to a perforative attack. I am well aware of the dangers, both primary and secondary, of an operation during an attack. I have seen only too many cases operated on too late. I know there is a distinct danger in the interval operation, even though a very small one, and I recognize the fact that it should not be lightly entered upon. I do believe that if every case was operated on early, the mortality would be reduced. But I also believe that by exercising care and discrimination in our cases we can reduce the mortality just as much, perhaps more than if we operated on every case, and we shall at the same time only be operating on those cases that need an operation. The grand ideal in the management of these cases is the hearty co-operation of the physician and the surgeon, together with that *sine qua non*, an intelligent patient. Very often, when the pros and cons are laid before such a patient he will unhesitatingly decide on the proper course of action. May we not hope that in the near future physician, surgeon, and intelligent patient, working hand-in-hand, will reduce the awful mortality of this dread disease—appendicitis!

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How is it then, with a case in which we have made the diagnosis of acute appendicitis, but in which the signs and symptoms are not severe enough to warrant an immediate operation? Here the problem is not so difficult. We keep the patient in bed, on a liquid diet. We give no cathartics, we give no opium, we give no morphine. Only in exceptional cases do we give enemata. We place a light ice-bag over the region of the appendix. We have a trained nurse at the bedside day and night; she counts the pulse every hour and measures the temperature regularly every three hours, and whenever there is an increased rapidity of the pulse. We examine the patient carefully three times every twenty-four hours and note the progress of the case. And just here lies the great danger in administering opium. We cannot correctly judge of the intensity of the symptoms if we deliberately mask those symptoms by giving narcotics. How can we tell if the pain has increased, after we have deadened it with opium? The same is true of the tenderness. Moreover, we are very apt to have tympanites develop if we give opium; and who can differentiate between such tympanites and that of a beginning peritonitis? No,

let us administer no opium, but rather give nature full sway and allow her, as the disease progresses, to display her various danger signals. What are these danger signals? If we find the pain and the tenderness (for these are two different things) on the increase; if we find the abdominal wall, which the day before was soft even on the right side, becoming rigid, then we advise operation, even though there has not been much change in the pulse or temperature. If at any time in the course of an attack a chill manifests itself, immediate operation is imperative. If the pulse, as the disease progresses, does not show a tendency to become slower, but rather more rapid, even though the temperature is but slightly elevated, the appendix should be removed. Persistent nausea or vomiting is generally associated with obstinate constipation, and means an involvement of the peritoneum—rarely operation is advisable, even in the presence of a slow pulse. A rapid pulse with high temperature early in the disease means pus; we should operate even though we cannot feel an abscess. There may be no abscess—the pus may be inside of the appendix (empyema.) In some doubtful cases the presence of a marked leucocytosis will aid in confirming our diagnosis of pus. If we feel an abscess forming, we watch our patient very carefully and, if possible, wait a few days until firm adhesions form. We must not expect to get fluctuation, for we very rarely do.

What shall we do when we have tided him over the first attack? Shall we advise every person who has had one attack to have the appendix removed? Many surgeons and some physicians do so advise. Unless the attack has been a severe one, I would not, in every instance, advise the removal of the appendix after one attack. There are undoubtedly many cases of catarrhal appendicitis that, with careful regulation of diet, proper exercise, and mild saline laxatives, are for years following a first attack entirely free from symptoms. Such patients should have appropriate treatment, and should not be urged to have the appendix removed. At the same time, I believe it is but fair to warn them that they are in danger of having a second attack at any time, and that the second attack may be much more serious than the first. Such a patient, who has had one even moderately severe attack, should not travel in unfrequented places, or go to any place where he cannot have prompt surgical treatment if the emergency arises. It is for the intelligent patient to decide in such a case whether he wishes to have his appendix—his sword of Damocles—removed. And many such patients will so decide; especially as they often



have uncomfortable sensations in the region of the appendix. But such patients should not be told that the interval operation is entirely free from danger. There is danger in every administration of an anæsthetic, there is danger in every operation. True it is, the risk is very small, especially when compared with the dangers of a second, more severe attack of the original disease. Should a patient have had two attacks, I would in every instance advise the removal of the appendix. In so advising, I am well aware that some persons get along very well even for years after a second attack; for I have myself seen such cases. But the danger of a third attack is too great, and it is doubtful if there is ever a *resitutio ad integrum* after two weeks of appendicitis. Moreover, the third attack is apt to be more severe than the previous ones; nor is any one able to say how near an appendix that has been twice inflamed is to perforating.—*Jos. Wiener, M. D., in Medical Record.*

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Women, as a class, assume that most of their distress, pain and suffering originates in, or results from their genital organs, and look upon their sex as a providential curse. They are, therefore, always ready to believe, with but little encouragement, that some special disorder exists, and thus they become the victims of unnecessary and painful examinations and much needless local treatment, or as Price would say "gynecological tinkering." Pain in the ovarian region, dysmenorrhea, leucorrhea and backache are often but the expression of a poorly nourished body and an unbalanced nervous system, worn out by excessive cares and anxieties, and driven to exhaustion by unrequited affection and domestic infelicity. Medicine being an inexact science, commands many agencies potent for good and often fraught with harm, and these are placed into the hands of careless, unqualified and often unscrupulous medical men, and as a result, simple functional disorders are converted into gross lesions which only skillful and desperate surgical procedures can remedy. Pain is no doubt the most frequent symptom which we are called upon to treat, and is the one which most readily begets our sympathy, and should have our best professional thought. It is a symptom of so many varied conditions, and is so complex in its origin, being often most acute in purely functional disturbances, that it is frequently assumed to be the expression of some serious lesion, and as a result, many needless mutilating operations have been vainly tried for its relief. Many women have been operated upon for the relief of pain, in

whom gross painful lesions existed, and yet were not relieved of their pain by the operation, because there was also present, a reflex pain and tenderness, or a brain pain, which may have been due to the presence of the growth of the inflammatory exudate, or may have been independent of them altogether.—*H. E. Hayd, in Buffalo Medical Journal.*

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Dr. Frederick A. Packard reports in the *Archives of Pediatrics*, three cases of meningitis in infants in which there was an entire absence of Kernig's sign at all stages of the disease.

An autopsy was held in all three cases verifying the diagnosis. Two of the children were 16 months old, the other 4. He believes that in the diagnosis of this trouble in children and adults Kernig's sign is of undoubted value, but its absence in infants should not have too much weight in excluding the disease.

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There is an oft repeated formula that all surgeons should at least have five years' experience in the general practice of medicine before entering upon the practice of surgery. Nearly all the older surgeons have to an extent continued such a general practice throughout their careers. The demands of modern surgery will not permit of such a course. The recent medical graduate who determines upon a surgical career will perfect himself far better by a two years' service as a hospital intern in a well regulated hospital, taking all the services in course. This will afford him the opportunity of perfecting himself in clinical diagnosis including the usual pathological, urinary, blood and microscopic examinations. It will require his entire time to develop any important degree of proficiency in these departments. The two subsequent years may be profitably spent in laboratories for physiological chemistry, general and comparative pathology, bacteriology, anatomy and experimental surgery. These courses will of necessity be taken at large hospitals or universities where abundant material is offered for investigation. During this time his bedside experience will be necessarily limited, but the advantages of an out-door service may be secured. He is now in position to assume an assistantship in the operating room of the surgical clinic and to begin the actual life work, and at the conclusion of another year is ready to assume the responsibilities of operative surgery for himself.

Such a course of post-graduate study faithfully pursued will give advantages that are inestimable. The highest order of work

demands all these attainments. The modern surgeon must be equally at home at the bedside, in the clinic and in the laboratory. He must be able to direct if not conduct each department. They are dependent each part upon the other and require equal cultivation in order that the symmetry of the whole may be maintained. —*Willis G. MacDonald, M. D., in Medical News.*

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Who among us has not felt the thrill of satisfaction, the poignant joy of power possessed, when vanishes disease, a vanquished foe, before the healing hand of hardearned knowledge? No thought of worldly gain; no lust of money gets entrance at this psychological moment, when the true inwardness, the real and human soul of the physician reacts to the testimony of his own skill.

And when disease, with evil eye and devilish persistency, lurks among us, and effects, at each succeeding step the baffling of our every move, advancing on and trampling our but too meager forces, pilots the way, now swift, now slow, now wavering, now sure, for Death, the great implacable, the merciless and final foe; when, I say, disease to us and our efforts proves irresistible, who among us has not felt the sting of defeat, the weakness of our sometimes vaunted strength? And perhaps there are those among us to whom the lash of conscience has been sharp, unsparing, and severe, forcing upon our unwilling selves the recollection that not every stone, perhaps, was turned in time to tell against the forces of the mortal enemy. And in these moments no thought of self, no assurance of monetary gain, can be a balm to the natural and psychological period of depression.

And so it is made plain that the pecuniary emolument is not alone the resultant for which we strive; and it is obviously well that it is so. Let us, therefore, with a will, and a consciousness of no omissions which might threaten the welfare of the strong as well as the weak and ill, bend our efforts toward the annihilation of the forces which attack humanity.

And of the reward?—What is success?—*J. Wilkenson Jewey, M. D., in New York Medical Journal.*

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The treatment of suppurative otitis media in young children by Geo. L. Richards, M. D., in *Medical News*. I will outline the method I am in the habit of using, which varies a little according to the length of time the suppuration has lasted and the degree of damage which the ear has already sustained. If the suppuration has lasted some time, the discharge very foul and caries of the



tympanic structures already marked, I syringe the ear thoroughly with warm sterile water or with a solution of 1 to 5000 bichloride of mercury until all debris has been removed. The canal is then carefully dried and the ear inspected. If there is much destruction of the tympanic membrane, I apply peroxide of hydrogen on a cotton pledget (never dropped in) as long as there is any exudation of gas, and after again drying the parts, apply on a cotton pledget a saturated solution of boracic acid in from forty to ninety per cent. of alcohol; the percentage of the alcohol depending on the age of the child and the ability to bear the pain of the alcohol. In young children I seldom use over fifty per cent. alcohol. I next dust the whole surface *lightly* with powdered boracic acid or some similarly acting powder; of late I have been using boric acid and acetanilid with good results, also at times aristol, acetanilid, or euophen combined with stearate zinc. These are all drying powders and I regard them as very useful, although some object to the use of the powders at all. A powder can, however, be used with perfect safety in the ear if care is taken not to use too much and the powder is free from lumps. Lastly, I lightly stopper the ear with a narrow wick of iodoform or other antiseptic gauze, taking care that the gauze reaches to the bottom of the canal.

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I have been a pretty close observer for over forty years and I have never known a money-making doctor who was a successful practitioner, and the most successful practitioners I have ever known only achieved a decent competency and a great many scarcely that. If the laity properly understood that the equilibrium of their physician's mind had more to do in curing their diseases and saving their lives than the pills and potions he peddles, they would pay him better as a matter of pure self interest. No doctor of any school can exert his highest powers when his mind is divided between treating disease and getting bread, and I state it here as deplorable fact, that hundreds of human lives are yearly sacrificed because under our present system the doctor is compelled to give a great deal of thought to "what he shall eat and wherewithal he shall be clothed." Why do most people so dread a doctor's bill and put off its payment to the last moment? Why do they cheerfully pay the druggist, the grocer, the butcher, the baker and the merchant, and then if there is anything left they grudgingly dole it out to the doctor? Simply because we have educated them to believe that medicine cures them. They would

not want to pay you to tell them that they ought to buy a black coat or a pair of striped trousers any more than they would for telling them to take ipecac or quinine even though they complied with your advice. There is no financial standard for measuring the value of thought, hence they fail to estimate it in comparison with material things.—*J. T. McColgan in Wisconsin Medical Recorder.*

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Very commonly strychnine is given in too small doses to produce the effect it is capable of. One-sixtieth or one-fortieth grain of the alkaloid is of very little value even as a simple tonic, except in persons of abnormal susceptibility. I have habitually given, for many years, the tonic dose as one-twentieth grain three times a day, and have never seen a case in which it produced anything like serious symptoms. In nervous females such doses will sometimes cause increased nervousness, or perhaps sleeplessness. In a very few cases that I have met with, as an idiosyncrasy even the smallest doses of strychnine cause vomiting. Very frequently it is better in the use of the drug to give none of it after 3 or 4 o'clock in the afternoon, and then secure the patient from wakeful nights.

As a general and respiratory stimulant strychnine is very valuable in acute pulmonic diseases, but here, in order to be effective, it should be given in full dose at short intervals. One-twentieth of a grain hypodermically, every four hours, in a pneumonia or in a low fever, is only moderate dosing, and especially do the old bear strychnine well. Their nerve centers are evidently so hardened by the vicissitudes of years that they are only to be affected by inordinate stimulation.—*Dr. H. C. Wood, New York.*

This appeared as a complete article in the GAZETTE some time ago; but the above is so good it will bear repetition.

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Scarcely anyone outside the profession can realize the extent to which, in these latter days, the personal solicitation of medical men by representatives of book publishers and drug firms has progressed. Most of us, from a desire not to be uncivil, have thus far submitted to the imposition with what grace we could summon, causing thereby a vast increase in the number of agents, a growing consciousness on their part of owning the entire profession, an office chokeful of useless samples of every possible and impossible formula, and a damaging loss of the physician's time.

We believe that drug men should confine themselves and their advertising matter to the press and the mails. It is trying enough to one's temper to receive by mail a sealed advertisement, but when we are desired to sit meekly for a quarter or half hour every day and listen to a glib discourse on the chemistry of foodstuffs or the predigestion of milk, or the destruction of bacteria by a patented germicide, we think it time to rebel. Many drug firms confess, if questioned, that they maintain at a loss the practice of visiting the houses of physicians and leaving samples of medicines and appliances; they feel, however, that they must maintain the nuisance in order to keep the pace set by business rivals. The following notice was recently found in the hallway of a physician of large practice in this city. He claimed to have been "driven to it by persecution:"

"Dr. ——— positively refuses to be interviewed by representatives of any book-publishing firm, or the makers or agents of any line of drugs, proprietary preparations, or surgical dressings."—*Gallard's Medical Journal*.

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The rules of medical ethics, but little understood by the public, are like the rules of whist, not intended to enable unscrupulous or designing men to act under the guise of honesty, but merely to serve as a guide to the man of honest intention in certain perplexing emergencies. Like the Bible, the code of ethics makes its rules and conduct personal to the individual; it says, "thou shalt," and "thou shalt not," wholly irrespective of what the other man is doing. Now it may be objected that the Bible itself has lately been subjected to a good deal of what is, I believe, termed the "higher criticism"—higher because it takes upon itself to criticise more freely than ever before; so that it has become necessary to write ponderous tomes for the interpretation of the Bible, until it would almost appear doubtful what the original meanings might have been. The code of ethics requires no interpreters; it is intended to help the man who wants to do right; it is the willingness to deal fairly with all men which is requisite.

—*Joseph Eichberg in Cincinnati Lancet-Clinic*.

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It is a trite saying that the general practitioner makes the best specialist. Certainly a man who has spent several years in general practice is best qualified to take a fair and broad-minded view of a special subject. It is the well-known tendency of specialists to attach undue importance to single symptoms and, in their anx-



iety to discover some lesion of the organs in which they are especially interested, to lose sight of the intimate relation between those and the entire body. This is the reproach which rests especially upon gynecologists. For example, it would seem almost self-evident that retroversion of the uterus in a patient with general muscular atony, flabby abdominal walls, relaxed pelvic floor, and displaced abdominal viscera, is but a single indication of a general faulty condition. Yet it is only within the past few years that the condition known as enteroptosis has been generally recognized, and even now many gynecologists disregard Kellogg's dictum that the cure of retrodisplacement is only the first step in a course of treatment intended to restore the general muscular tone. Again, the phenomena exhibited by many patients, especially pains over certain well-known regions, are often erroneously attributed to reflex disturbances arising from a prolapsed ovary, or a minor lesion such as a lacerated cervix, when they are really an expression of a general, rather than a local trouble. The subject of reflex neurosis has been an inexhaustible mine to gynecologists in the past, but, to continue the metaphor, it has been pretty thoroughly worked out. There are evident signs of a revolution on the part of the general practitioner against this tendency of specialists to extend the boundaries of their activity.—*Henry C. Coe, M.D., New York, in Medical News.*

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I denounce the use of the chloral of the shops for alcoholics. It came to us as such a "nice" hypnotic, "not upsetting the digestion," and "giving a peaceful sleep." As was to be expected, it was largely used first in asylums, but now I should as soon ask the superintendent if he used restraint as chloral. Mental derangements of alcohol habitues are produced by its use; and more than that, it produces moral perversion. In my experience it produces a tendency to impulses, under which homicide or suicide is irresistibly induced. Drink may cause insanity, but drink gets often blamed for this when chloral makes the fault. There is no readier means of provoking mental insufficiency, and that of the meanest and most base character, than by giving chloral to the inebriate.

I am contradicted. I know that there are eminent physiologists who will deny my statements, and who can show that chloral hydrate obviates and antagonizes the effect of alcohol. But they speak of pure, especially-prepared chloral hydrate, not ordinarily found on the 'apothecary's shelf; I speak of that which is

commonly found with the druggist. They are right, quite right, as concerns pure chloral; but administer the ordinary article. You are giving it, remember, to a patient where alcohol has impaired the nutrition of the brain. The starved brain responds more or less quickly by suspending its functions in one way or another. The meninges are congested, the respiratory centers paralyzed or obtunded, and the organic nervous actions are suspended. Show me, if you can, a more damaging influence to cause insanity.—*Gifford Knox in The American Practitioner and News.*

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In tracing the results from eighty-five cases operated on for ovarian and tubal diseases, the patients being under observation for a year subsequent to the operation, Dr. W. L. Burrage arrives at the following conclusions (*Annals Gynecology and Pediatrics*):

1. It is advisable to do conservative operations in all cases where the ovaries and tubes are not hopelessly diseased in all parts of their structure, except on patients who are near the menopause, on patients who have pronounced gonorrhoea of long standing, and on the rare cases of malignant disease.

2. When a patient is near the menopause (over thirty-five years of age) and has ovarian or tubal disease of any considerable degree of severity it is generally wiser to perform complete removal with or without hysterectomy, according as the uterus also is diseased or not.

3. In cases of well marked gonorrhoea of long standing, especially if the patient is constantly exposed to reinfection, if both tubes are seriously diseased and closed, total removal with or without hysterectomy is the operation of choice.

4. In certain cases of this class where the patient thoroughly understands the likelihood that another operation may be necessary at some future time and wishes to take the chances in the hope of preserving the function of menstruation, conservative operation is permissible.

5. If one tube is patent and healthy in appearance and there is enough healthy ovarian tissue to preserve, a conservative operation ought to be performed even in the presence of gonorrhoea.

6. With present methods of performing resection of the tubes, if both tubes are found closed at the time of operation, subsequent pregnancy is not to be expected.

7. In severe grades of inflammation of the appendages irrespective of causation, if the ostium abdominale of one tube is

patent the prospect of subsequent pregnancy after the preservation of a portion of ovary is about one in four and a quarter, or  $23\frac{1}{2}$  per cent.

8. In the less severe grades of inflammation under similar conditions of tube and ovary the prospect of subsequent pregnancy is about one in two and a quarter, or 44 per cent.

9. In women who have borne children, in both classes, subsequent pregnancy may be expected in 35 per cent., whereas in previously sterile women it may be looked for in only 5 per cent.

10. If it is necessary to remove both ovaries it is of no advantage to preserve any portion of tubal tissue, but, except under the conditions just enumerated, some ovarian tissue should be preserved in every case.

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"The Differentiation of Chorea and the Disorders Simulating It," (*Journal*, July 21, 1900), is discussed by A. A. Eshner, M. D., Philadelphia. True chorea (Sydenham) in its invasion, seasonal prevalence, self-limitation, endocardial and articular complications, liability to recurrence and pathology, simulates an acute infection. The infectious theory is credited by many. Chorea is a frequent sequence of rheumatism in children. He cites three German authors who found a micrococcus in the blood, brain and cardiac vegetations of a rheumatic and choreic patient, capable of producing polyarthritis when injected into animals. Other cases showing a close relation between the two affections cited. Onset of the disease is often sudden though without the usual sign of an acute infection. Most common in the spring. By arsenic treatment, regarded as almost a specific, the duration is six to eight weeks.

Endocarditis is commonly a sequel, sometimes a complication or antecedent. Arthritis is occasionally an antecedent or temporary, rarely a sequel. Movements either increased, restrained or unaffected by voluntary motion.

Chorea: Movements are jerky, irregular, disorderly, incoordinate, purposeless, sometimes violent and incessant. They cannot be voluntarily controlled. Cease during sleep. Reflexes capricious. Temper irritable. Muscular weakness, even simulating paralysis. Facial expression often fatuous or foolish.

Habit chorea, habit-spasm, spasmodic tic.: Occurs in neurotic individuals, has no relation to rheumatism, does not simulate an infectious disease, no cardiac complications. Causes are peripheral irritation of ocular, nasal, oral, prepuccial, intestinal origin



and from habit. Movements are co-ordinate, purposive, repetitive. Fleeting and do not interfere with voluntary motion. Facial movements most common as grimaces, blinking, distention of the nares, etc. May persist for years, cease during sleep and are under voluntary control. Facial-spasm involves one or several muscles of the face, is associated with paralysis of the facial nerve, occurs in adults, is relieved by rest and increased by motion. It is irregular in course, painless and of long duration.

Athetoid movements are more vermicular, less jerky and abrupt than chorea. They are increased by voluntary motion, are associated usually with palsy and other spastic phenomena and accompanied by a condition of mental deficiency. Senile chorea (Huntington) occurs in adult and late life, is of gradual onset; the movements are less abrupt and jerky than in chorea, the gait is staggering. The condition is often hereditary and not amenable to treatment.

In hysteria, choreiform movements are of more abrupt onset, more rapid, more shock-like and rhythmic and associated with other hysterical stigmata.

Chorea major is probably of hysterical origin.

Dubini's disease, electric chorea, is of infectious origin and attended with muscular weakness and atrophy. In torticollis or spasmodic wry-neck the movements are confined to a few muscles and always of the same character.

Rotary spasm, observed in rachitic children, is limited to the head, occurs in very early life. H.

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A number of excellent editorials upon the various phases of typhoid fever occur in the March 3d issue of the *Philadelphia Medical Journal*. A resume is as follows: Typhoid fever, an infectious disease, may occur as a generalinfection or bacteriemia without involvement of the intestine; or the spleen, lungs, kidneys, etc., may be especially affected. For more accurate clinical diagnosis culture growing from the stools, urine, blood and sputum is recommended, or for pathological work from spleen, kidneys or lungs. The agglutinating or sedimenting of the bacilli in culture when treated with blood serum during or after an attack is all but infallible. The diazo-reaction is of much value.

If the excreta, stools, urine and sputum (latter especially in pneumo-typhoid) and the bodies of those dead of the disease were properly disinfected typhoid might be eradicated.

Filtration the most efficient practicable means of water purification. Epidemic in York, Pa., traced directly to milk infected by washing the cans of a dairy at a spring into which infectious material drained.

One of the German synonyms for typhoid, *nerven-fieber*, suggested by frequent cerebral symptoms resulting from high temperature, specific intoxication or local cerebral complications. Bathing and nourishment reduce nervous complications. Case of delirium in a convalescing typhoid simulating that of inanition relieved by whisky 3 ounces in twentyfour hours and hypophosphites with strychnia.

Professors Herdman and Boyce, for Lancashire (England) Seafisheries Commission, report inability to isolate the typhoid bacillus from oysters, that seawater is inimical to its growth. Colon bacillus was demonstrated in market oysters. Oysters are probably free from typhoid infection unless contaminated after leaving salt water.

Dr. A. C. Abbott points out that typhoid may be an autumnal fever, not so much because of climatic influences as of conditions governing the purity of the water supply. A similar relation between malaria, mosquitoes and stagnant water may exist.

Typhoid infection of the gall bladder is nearly always present during the course of the disease, although not always manifest. Chiari reports 19 of 22 cases had typhoidal infection of the gall bladder. Empyema, ulceration or cholecystitis without calculi may occur. Bacilli by causing stagnation, or themselves clumping form nuclei and cause precipitation of salts. Infection through intestine, blood or gall ducts is possible. Two cases of primary gall bladder infection with typhoid are reported.

Length of persistence of typhoid infection was fourteen years in one case, forming abscess finally. A case with abscess seventeen years after fever with pure culture of bacillus typhoidens is reported. Operation necessary from cholecystitis empyema, cholelithiasis, necrosis, ulcer, perforation, etc. Operative results encouraging.

Typhoid complicating pregnancy causes abortion or premature labor in 56 per cent. Hare, 65 per cent. Hirst. The Widal test is demonstrable from the placenta, fetus and milk. Some difficulty in diagnosing between typhoid and puerperal fever. Hirst gives the prodromata, rose spots, temperature and Widal reaction as diagnostic. Subinvolution uteri is common.

In Munich in 1858, when the water supply came from the river Isar, there occurred 334 deaths per 100,000 of inhabitants from typhoid. In 1865 pure mountain water was introduced, and in 1894 the death rate from the same disease was 2.5 per 100,000. In Vienna a similar experience occurred, the death rate falling to 5 per 100,000. H.

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I. H. Coriat (Tufts College Medical School), investigating the action of rennin upon milk digestion, cites the first proof (by Hammarsten in 1872) of the distinctive coagulating power of rennin. The latter observer separated the active principle from pepsin, naming it *lab*, showed its action was the splitting up of casein into soluble and insoluble proteid, that it acted most favorably with calcium phosphate, and that the process was analogous to the clotting of blood.

Coriat says coagulation may be caused by

1. Direct bacterial action.
2. Indirect bacterial action forming lactic and butyric acids.
3. By addition of acids.
4. By soluble bacterial enzymes.
5. By vegetable coagulating enzymes.
6. By animal coagulating enzymes.

Reactions of rennin are given, the chief differences between it and pepsin are shown by a table.

If milk is coagulated by an acid and the coagulum re-dissolved by an excess of the acid, rennin will still cause recoagulation, showing its action to be different from that of an acid. The action of rennin forms paracasein, a difficultly soluble body and whey proteid, simulating albumose and readily dissolved. By tabulated experiments he shows that with rennin present more albumose peptone is formed than when pepsin alone is acting.

1. Rennin splits up casein in easily digested proteids.
2. When rennin is present more albumose-peptone is formed.
3. Rennin assists the action of pepsin and pancreatin.

In comparing the coagulating powers of animal and vegetable enzymes he concludes that under the same conditions their actions are equal. HCl, combined or free, must be present in greater amount than 1-10 by volume before it causes coagulation. But the action of rennin or vegetable enzymes is promoted by the presence of free or combined HCl. H.



In the chairman's address on obstetrics and gynecology W. E. B. Davis, M. D., of Birmingham, Ala, discussed their intimate relation, holding the two should be taught by the same instructors, and all such cases to be under one control. "The pyramid of experience, learning and skill is a stable edifice, a pillar of strength which cannot topple nor reel." The professional qualities of the true specialist form a massive pyramid whose capstone is his specialty.

In discussing gynecological process he said: "The more local disease we are compelled to remove the sooner the patient gets well, and the less the disease and the greater the amount of nervous trouble, the slower is the case to recover."

The abdominal incision is usually preferable. Puerperal inflammation should be operated on without awaiting pus formation. By early section and drainage convalescence is hurried. Fibroids, unless of very large size, can be enucleated. He condemns the treatment of renal pus formation through the ureters when lumbar incision is simple. In operating for biliary calculi it is unnecessary to stitch the ducts after removal of a stone from them. Drainage by gauze and a glass tube is perfectly safe and prevents biliary intoxication. Stitching the gall bladder to the wound not necessary. Statistics cited.

In closing the abdomen interrupted silkworm uniting aponeurosis, recti and peritoneum, held by silver tubes projecting above skin, with shot to hold, are used. H.

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George M. Gould, M. D., Philadelphia, in the *Journal*, July 21, 1900, discusses the ideal science of anthropology, based upon statistics of periodic examinations of every individual, including (1) hereditary data, (2) developmental and historic, (3) morphologic, (4) physiologic, (5) psychologic, (6) pathologic, and (7) the factor of heredity. He enters a plea for more careful physicians and hospital records as the most valuable of all statistics. Continuing, he says: "It is the shame of medicine and the basis of quackery, this symptom-treating and symptom-killing. What a horrible fact—this of the vogue of pain deadness!" "True medicine is to stop the cause of symptoms, to prevent the symptoms from arising." "The pathologist's final problem is to prevent pathologic specimens from ever coming into his hands." "The whole ingenuity of the trained diagnostician is now expended on the problem of the earlier symptoms." Paresis, locomotor ataxia, gout, nephritis, arterio-sclerosis, diabetes, all have

minute beginnings. "Even the growth of bacterial disease depends on the soil in which they are sown." After a very humorous array of the general practitioner against the specialists he makes the well-grounded statement, "The specialist is fatally inclined to treat the disease; to the generalist must be left the far more important treatment of the patient." H.

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Serotherapy as an agent for the relief of surgical sepsis has been disappointing. The antistreptococcus serum of Marmoreck has not justified the earlier claims of its discoverer. However, we have seen enough to encourage us in the perfection of the serum. It can hardly be expected to cure mixed or unusual varieties of streptococcus infections. As a preliminary to further study of antistreptococcus serums, a thorough re-investigation of the streptococcus order is essential. There are always many facts observed that indicate that there are many subvarieties of streptococcus presenting independent clinical characteristics. Varieties must be isolated and so combined in culture that the resulting serum is antidotal to the kind found at the seat of the infection. The utility of the serum treatment of diphtheria is so established that there can be no doubt but that others will be discovered equally effective. The tetanus serum certainly possesses antidotal properties. When given in suitable quantities, I have invariably seen improvement follow its use and in one case I believe it was a life-saving agent. In this latter case nearly five hundred cubic centimeters of serum were given in two doses. In my experience the prescribed dose is far below the quantity required. Enough results have been obtained, however, to justify further and most painstaking investigation. Serotherapy must, however, be employed in conjunction with laboratory methods if it is to occupy an important position in the treatment of surgical infections.—*Willis G. MacDonald in Medical News.*

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## Editorial.

### LEGALIZED CHARLATANRY.

Among the applicants who presented themselves for examination at the U. S. recruiting station in this city some weeks ago was a man with a very suspicious eruption on the chest, back and thighs. A careful inspection revealed no other evidences of syphilis, there being, however, two small, non-indurated abrasions upon the fore-skin.



The applicant was rejected on the diagnosis of probable syphilis, and an hour later appeared at the office with the following note, written by a "specialist" in the Arcade:

"To Whom it May Concern:—I have carefully examined A. B. and find the eruption on the skin of a trifling nature, entirely bland, non-irritating and non-poisonous. Yours,

"D. F. QUACK."

The man, having been an old soldier, and very anxious to join the army again, was finally told that if he would submit to an examination by Dr. W. T. Corlett, of this city, and the latter could *positively* state that the lesions *were not* the result of syphilis, he would be enlisted.

Having readily consented, the next day he presented a note from Dr. Corlett pronouncing it unquestionably a case in the secondary stage of syphilis.

There was little question of the diagnosis from the first, although it was one of those uncertain cases that few, other than a specialist of dermatology, would feel qualified in essaying a private opinion upon at once.

Cases, similar to this, are entirely too frequent where physicians, being unable to arrive at a correct understanding of a case, seem loath to suggest a consultation, preferring to worry along in the dark.

Medicine is too vast a subject for any one man to master, and there is no discredit in frankly admitting one's limitations. There is very great discredit, dishonor and dishonesty in not so doing when a mistaken diagnosis, or no diagnosis at all, may be the cause of far reaching and disastrous results.

It is said that men belong to one of four classes: Those who *know*, and know that they know; those who *know*, and do not know that they know; those who *don't know*, and know that they don't know; and those who *don't know*, and don't know that they don't know.

Every well qualified physician has a small field, wherein he belongs to class No. 1—he knows, and he knows that he knows. Beyond this, there extends a field as unbounded as the skies, where his intelligence places him in class No. 3. He doesn't know, and he is keenly alive to the fact.

The dangerous man, the one who is a drag and a disgrace to the profession, and a menace to society, is the one who doesn't know, and doesn't appreciate the fact, or perchance, if he does, will admit it to no one but himself.

These men are the mountebanks of the regular profession; they are legally qualified to assume the responsibility of guarding human life, and yet no one is entirely safe in their keeping.

The causes underlying this condition of affairs it is not our purpose to discuss at present. That such conditions exist, and that these men abound in every community there is no question.

The advertising "quacks"—the men who at least have the honesty to acknowledge themselves charlatans—are probably not so productive of harm as this other class of men who choose to masquerade in sheep's clothing.

G. SEELEY SMITH.

THIRTEENTH ANNUAL REPORT OF THE STATE  
BOARD OF HEALTH OF THE STATE OF OHIO,  
FOR THE YEAR ENDING OCTOBER  
31, 1898. COLUMBUS, 1899.

TWENTY-FIFTH ANNUAL REPORT OF THE SECRETARY OF THE STATE  
BOARD OF HEALTH OF THE STATE OF MICHIGAN, FOR THE  
FISCAL YEAR ENDING JUNE 30, 1897. LANSING, 1899.

The first of these reports is an unbound volume of 689 octavo pages with a disappointing index. It includes a "General Report" with special reports on "Contagious Diseases," on "Public Water Supplies," "Sewerage Systems and Sewage Disposal Works," certain miscellaneous reports, a "List of Cities and Villages Having Boards of Health, with Name of Health Officer" (June 1, 1899), "Annual Reports of Local Boards of Health for the Year Ending December 31, 1898," an "Abstract of Reports of Deaths and Their Causes in the Following Cities, Towns and Townships in Ohio for the Year Ending December 31, 1898," and several appendixes, to-wit: I. Second Report of an Investigation of the Rivers of Ohio as Sources of Public Water Supplies. By the Ohio State Board of Health. 1899. II. First Report Upon the Condition of the Public Water Supplies of Ohio. By the Ohio State Board of Health. 1899. III. Proceedings of the Ninth Annual Meeting of the State Board of Health and Local Boards of Health of Ohio, Held in Columbus, O., Jan. 19 and 20, 1899.

The report of the Secretary of the State Board of Health of Michigan is a well printed and fairly bound volume of 600 pages, with an elaborate and useful general index and an excellent special index of subjects and authors found in the publications of the Michigan State Board of Health for the past twenty-five

years. It is divided into two parts, the first containing the Secretary's general report of the administration of the board, together with valuable papers on the "Treatment of the Drowned, Suffocated and Electrically Shocked," by Henry B. Baker, M. D.; "Teaching Sanitary Science in the Schools," by Prof. Delos Fall; "Suggestions on Public Health Work in Michigan," by Hon. Frank Wells; "Disinfection of Rooms," by Prof. F. G. Novy, M. D., and H. H. Waite, A. B., and on Scarlet Fever, by Dr. Henry B. Baker.

The second part contains numerous papers, abstracts and reports on the meteorology of Michigan, the time of prevalence of diseases, on the communicable diseases, poisonous soap, polluted water, injuries from the use of kerosene and gasoline, including extensive and valuable statistics on the subjects of sickness, meteorological conditions, etc., all of great interest to students of public health.

Both reports are valuable and interesting to sanitarians, and that of Dr. Baker, the well-known Secretary of the Michigan Board of Health, leaves little to be desired in this special line of work.

H. E. H.

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#### CLEVELAND MEDICAL LIBRARY—NEW BOOKS ADDED.

Purchased: Valentine, Ferd C., *The Irrigation Treatment of Gonorrhoea, Its Local Complications and Sequelae*, 1900; Senn, Nicholas, *Pathological and Surgical Treatment of Tumors*, 1900; Lilienthal, Howard, *Imperative Surgery*, 1900; Butlin, T. H., *On the Operative Suregery of Malignant Disease*, 1900; Scudder, C. L., *The Treatment of Fractures*, 1900; Robson, A. W. and F. Macrae, *Diseases of the Gall-Bladder and Bile-ducts, Including Gall-Stones*, 1900; de Meric, H., *Dictionary of Medical Terms: French-English, English-French*, 2 vols., 1900; Shield, A. M., *Diseases of the Breast*, 1898; Durck, H., *Atlas Special Pathologic Histology*, 1900; Kelly, H. A., *Operative Gynecology*, 1900; St. Bartholomew's Hospital Reports, vols. 32-35 (to date); St. Thomas's Hospital Reports, vols. 8-13, 19, 21, 1877-1883, 1889, 1891; *Archives of Neurology and Psychopathology*, vols. 1, 2, 1898, 1899; Deaver, John B., *Surgical Pathology*, 2 vols., 1900; *Progressive Medicine*, June, 1900.

Donated: Hartridge, G., *Refraction of the Eye*, 1900, from Dr. W. E. Bruner; *Contributions to the Science of Medicine* by the



Pupils of W. H. Welch, 1900, from Dr. H. K. Cushing; Gamboa, R. S., *Mongrafias Clinica Quirurgica*, from Dr. C. Al. Hamann; Mantegazza, P., *Hygiene de L'Amour*, from Mr. J. W. Walton.

From Secretaries, etc.: New Jersey State Board of Health, Report for 1899; Proceedings of Soc. of American Anatomists, 1899; Proceedings of the Path. Soc. of Philadelphia, 1900; Ohio State Board of Health, Report for 1898; Ohio State Board of Health, Investigation of Rivers, etc., of Ohio, 1899; Transactions Rhode Island Med. Soc., vol. 6, part 1, 1899; Ohio Hospital for Epileptics, Report for 1899; Transactions State Medical Society of Kentucky, vol. 8, 1900.

Donated by Dr. Dudley P. Allen: Bigelow, H. J., *Orthopedic Surgery and Other Medical Papers*; Bigelow, H. J., *The Mechanism of Dislocations and Fractures of the Hip—Litholapaxy, or Rapid Lithotomy with Evacuation*; Higelow, H. J., *Anaesthesia, Addresses and Other Papers*; Bigelow, H. J., *A Memoir of*, 1900.

#### CLEVELAND MEDICAL LIBRARY ASSOCIATION NURSES' BUREAU.

New Members: Miss Olga Wise, Maternity Hospital and Lakeside Hospital, city; Miss Agnes Meyer, Charity Hospital, city; Miss Florence Oakes, Bethany Home, city; Miss Margaret Carnahan, Maternity Hospital, city; Miss Anna Jackson, graduate, City Hospital; Miss Mary Robertson, graduate, City Hospital.

The American Association of Obstetricians and Gynecologists will hold its thirteenth annual meeting in the Assembly Room of the Galt House, Louisville, Ky., Tuesday, Wednesday and Thursday, September 18, 19 and 20, 1900, under the presidency of Dr. Rufus Bartlett Hall, of Cincinnati, O.

A cordial invitation is extended to the medical profession to attend the several scientific sessions of the association.

The *Journal of Surgical Technology* is the title of a new periodical, to be published monthly, beginning July 1, 1900. It will be devoted to the consideration of the technic of surgical procedures, at a subscription price of \$1.00 a year. Premiums are offered with the first subscriptions. Address the Technique Publishing Co., 404 East 14th St., New York City, for sample copy.

The following is abstracted from the editorial pages of the *Lehigh Valley Medical Magazine* for August:

"Marked Success of Vaccination.—The *Philadelphia Press*, in an editorial appearing in a recent issue, calls attention to the triumph of vaccination in Porto Rico. Under the negligent Spanish administration smallpox was everywhere prevalent in the island; the disease was greatly dreaded and was attended by high mortality.

After the occupation by the United States, wholesale vaccination was practiced in a way never before attempted, and the result has been practically driving the disease out of the island. The accomplishment of this, in one year's time, is astonishing. Surely the anti-vaccinationists cannot claim that the improved sanitary conditions are able in themselves alone to account for this remarkable change. This is an object lesson which ought not to be overlooked, and it should furnish material for a good argument to be used by the friends of vaccination."

If the reader will take time to refer to the May issue of the *GAZETTE* he will find there an editorial, "Eradication of Smallpox in Puerto Rico and in Ohio," which goes into the matter very thoroughly and gives considerable of the detail carried out to secure the eradication.

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## New Books.

A TEXT-BOOK OF PRACTICAL THERAPEUTICS. With Especial Reference to the Application of Remedial Measures to Disease and their Employment upon a Rational Basis. By Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital, etc. With Special Chapters by Drs. G. E. de Schweinitz, Edward Martin, and Barton C. Hirst. New, eighth edition, enlarged, thoroughly revised and largely re-written. Illustrated with 37 engraving and 3 colored plates. Cloth, \$4; Leather, \$5, net. Lea Bros. & Co., Philadelphia and New York.

To be successful in the practice of the medical science we must, above all else, be proficient in diagnosis. Next to diagnosis, and being a close second, we must be thoroughly conversant with therapeutics.

The fact that this text-book has reached its eighth edition in less than ten years proclaims it as a favorite with the practitioner and student. As stated in the preface, "In the present edition many therapeutic facts of value have been added, the general text

carefully revised, and an effort made to render the book still more useful for quick reference on the part of the busy practitioner. In addition to this a large number of important new remedies which have stood the test of clinical experience during the past two years have been added."

The work contains 798 pages, is illustrated with thirty-seven engravings and three colored plates, and is well bound.

To him who would be a good therapist, "One who, having pure drugs, knows when to use them, how to use them, and equally important, when not to use them," we have confidence in recommending this work.

E. S. LAUDER.

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**HISTOLOGY AND PATHOLOGY.** A Manual for Students and Practitioners. Nichols and Vale. Lea Brothers, publishers.

The authors in their preface assure us that "originality of data is little to be expected, and the chief object to be aimed at is arrangement and treatment of the subject in a manner convenient and clear to students and practitioners." The part devoted to histology differs in no essential way from the many manuals of histology now in the hands of the student, and is no doubt as good as most of the shorter treatises.

The division of pathology may be noted for its brevity, in short, being a collection of definitions. Sixty-five pages are devoted to general pathology, and the remaining one hundred and thirty-five to special pathology. It is too condensed to be used as a book for study, but would probably be useful to students who found it necessary to "cram" for examinations, which is just what we do not desire in a text-book. The part on normal histology is written entirely by Dr. Nichols, that on pathology entirely by Dr. Vale. The typography of the book is a good example of this publisher's excellent work.

R. G. SCHNEE.

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**ELEMENTS OF CLINICAL BACTERIOLOGY, FOR PHYSICIANS AND STUDENTS.** Levy & Klemperer. Translated by Augustus A. Eschner. W. B. Saunders, publisher.

The translator says, "We know of only one work on clinical bacteriology, and as a consideration of the subject must appeal to a large body of the profession, it was thought a service might be rendered by a translation of this admirable publication." The book is truly worthy of this translation, as it presents bacteriology



in an entirely new and novel light. As a text book for beginning students it is not well adapted, but for advanced students and practitioners it is exceptionally valuable. The authors have grouped the results of bacteriologic investigation from the clinical point of view and in this new edition have included the results of recent valuable investigations.

In part I. is taken up a consideration of the "Morphology and Biology of Bacteria, Infection, Immunity, etc., and Methods of Culture and Examination."

In part II. Inflammation and Suppuration, the morphology, pathogenesis and occurrence of their causative agents outside the body and in disease are fully discussed.

Specific Diseases of Bacterial Origin are described in part III.

The Mycoses or Infections with Filamentous and Budding Fungi, and Infections with the Lowest Forms of Animal Life are briefly considered in part IV. These subjects are brought up to date, making this part of great interest.

In the appendix are given methods of examination of Air, Soil and Water, with a table of the bacteria usually found there, also a brief description of disinfecting agents and the various methods of disinfection.

The book is nicely illustrated, printed in plain type on good paper, and is a credit to the publisher.

R. G. SCHNEE.

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**FACTS, FADS, AND FANCIES ABOUT TEETH.** Compiled and edited by Henry Lovejoy Ambler, M. S., D. D. S., M. D. Dean of Dental Department and Professor of Operative Dentistry and Dental Hygiene, Western Reserve University; Member National Dental Association; Ohio State Dental Society; Northern Ohio Dental Society; Cleveland Dental Society; Author of "Tin Foil and Its Combinations for Filling Teeth." Illustrations by W. L. Evans. The Helman-Taylor Co., Cleveland. 1900. Price postpaid \$2.

Dr. Ambler has certainly made a notable collection of anecdotes, clippings, extracts and quotations, and all about the teeth and the men who tinker them, and the unfortunate animals whose anatomy is not complete until their oral orifice is denticulated, and they thus become the victims of the Knights of Apolonia—Knights of Apollyon rather, the victim thinks. The doctor has arranged his facts, fads and fancies under chapter headings as follows: "Requests for Appointments," "In the Dentist's Office," "The Dentist," "Wit and Humor of Dentistry," "Women in

Dentistry," "Quacks," "Baby's Teeth," "The Mouth," "Bacteria," "X-Rays," "The Jaws," "The Gums," "Toothache," "Filling Teeth," "Laughing Gas," "Extracting Teeth," "Third Dentition, Toothless People and Peculiar Cases," Tooth Brushes, Tooth Powders, etc.," "History of Dentistry," "Proverbs About Teeth," "Quotations for Menu," "Quotations from the Bible," "from Shakespeare," "Poetical," "Prose," "Fashions and Customs," "Tooth-lore." In the refrain of the introduction, "And its all on account of the teeth, my friend, It's all on account of the teeth."

It is a book of 300 pages, prettily bound and ornamented with the color (lilac) of the National Association of Dental Faculties. As a frontispiece it has an engraving of the famous painting, Jan Steen-1626-1679; and there is also a full reproduction of Granacce's altar-piece of Apollonia the Patron Saint of Dentistry. The illustrator, Mr. Evans, with whose comical work in the newspapers we are well acquainted, has contributed very numerous sketches in his best style all through the book.

We congratulate Dr. Ambler on his very entertaining book, and the publishers, too, for it ought to be a good seller. Every dentist will thoroughly enjoy it, and both dentists and doctors will find amusement in the fads and fancies and instruction in the facts which it contains. The patrons of both dentists and doctors will while away time in waiting rooms pleasantly, obviously, while they peruse its pages.

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**DISEASES OF THE EYE.** By Edward Nettleship, F. R. C. S., Ophthalmic Surgeon at St. Thomas' Hospital, London; Surgeon to the Royal London (Moorfields) Ophthalmic Hospital. Revised and Edited by William Campbell Posey, A. B., M. D., Ophthalmic Surgeon to the Howard and Epileptic Hospitals, Philadelphia; Assistant-Surgeon, Wills' Eye Hospital, etc. Sixth American from the Sixth English Edition. With a supplement by William Thomson, M. D., Emeritus Professor of Ophthalmology in the Jefferson Medical College of Philadelphia. With 5 colored plates and 192 engravings. Lea Brothers & Co., Philadelphia and New York.

The fact that this excellent work from this eminent author has reached its sixth edition commends itself. It contains 560 pages and is divided into three parts, a supplement and an appendix. Part I considers means of diagnosis. Part II is termed "Clinical Division." Part III deals with diseases of the eye in relation to general disease. The supplement, written by Dr. Thomson, of Philadelphia, deals with the practical examination of railway employes as to color-blindness, acuteness of vision, etc. The

appendix contains formulæ, and information concerning bandages, shades, protective glasses, requirements of candidates for public services, etc.

As a text-book for students and a ready reference book for the general practitioner we feel satisfied that this book meets the essential requirements—the text being concise, yet explicit.

As an appreciative student of a worthy teacher we predict continued popularity for this work.

E. S. LAUDER.

**THE TREATMENT OF FRACTURES.** By Charles Locke Scudder, M. D., Surgeon to the Massachusetts General Hospital, Out-Patient Department; Assistant in Clinical and Operative Surgery in the Harvard Medical School. Assisted by Frederic J. Cotton, M. D., with 585 illustrations. W. B. Saunders, 925 Walnut Street, Philadelphia. 1900.

A thoroughly practical and up-to-date work upon the subject.

It is beautifully and fully illustrated and contains much of detail and practical interest, not to be found in the general text books upon surgery.

No surgeon who aspires to the latest and best in the surgery of fractures should be without it. G. S. S.

**ATLAS OF CHINA** Containing Maps and Descriptive Matter Pertaining to General Conditions and the Present Crisis in the Celestial Empire. Also a concise review of its History, Government, Religion, People, Industries, and Relation to Foreign Powers. Illustrated. Rand-McNally & Co., Chicago.

Coming as it does at this time when so much interest is centered in the Eastern empire this atlas fills a want. The maps include the following: Asia, China, proper; China, northeastern; Chinese empire, Dutch East Indies, French Indo-China, Hawaii, Korea, Malaysia, Oceania, Philippine Islands, Siam, World.

The atlas contains sixteen pages and is nicely bound.

E. S. LAUDER.

**A PRACTICAL TREATISE ON SEXUAL DISORDERS OF THE MALE AND FEMALE.** By Robt. W. Taylor, A. M., M. D. Second Edition, thoroughly revised. With 91 illustrations and 13 plates in color and monochrome. Lea Bros. & Co., 1900. New York and Philadelphia.

Dr. Taylor's larger work on venereal diseases is certainly one of the best works on that subject published to-day. This work is designed as supplementary to the former work in order to round



out and fully cover the subject of sexual disorders in the male and female. The reputation of the larger work is not detracted from by this smaller one. The same thoroughness, plainness of description and excellent treatment shown in the former is present in the latter.

The author has thoroughly revised this edition, adding considerable new matter and bringing it up to date in every respect. Among the new subjects is noted the enlargement of the dorsal veins of the penis as a cause of impotence; syphilitic oedema of the penis; tuberculosis of the prostate and seminal vesicles. Over seventy pages are allotted to the consideration of chronic affections of the male urethra, covering a subject that interests the general practitioner greatly. No physician at all interested along this line of thought can afford to be without a copy of this work.

W. CLARK.

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## Correspondence.

CEDAR RAPIDS, Ia., August 1st, 1900.

Gentlemen:—The Roentgen Society of the United States will meet in New York City December 13th and 14th, 1900, at the Academy of Medicine. Papers have been promised by eminent men abroad and here and very successful scientific meeting is assured.

There will be offered advantages to the visiting members for instruction in X-ray work that cannot be had under any other conditions. It is especially desired that all hospitals using X-ray apparatus, X-ray studios, physicians, surgeons and dentists doing X-ray work, scientific investigators, manufacturers and dealers in X-ray apparatus of all kinds throughout the United States should at once send their names and addresses to the chairman of Committee of Arrangements, Dr. S. H. Monell, 43 East 42d street, New York City, N. Y., so that they may be sent important notices regarding the meeting.

This society is the only one of its kind in America, national in character and for scientific purposes only.

Yours very truly,

J. RUDIS-JICINSKY, M. D.,

Secretary.

P. S.—All those wishing to become members or read a paper before the society may communicate with the Secretary.

## Notes and Comments.

**Dr. D. B. Smith** visited Toronto, Ont., during the last week of August.

**Dr. E. W. Woodford**, recently of Chicago, has located at 737 Detroit street.

**Dr. Walter H. Merriam** spent a few weeks in the Adirondacks during August.

**Dr. and Mrs. William Clark** spent two weeks' vacation from the city during August.

**Dr. Martin Friedrich** will have his office in the Rose Building after the 1st September.

**Dr. C. A. Hamann** will remove to 744 Prospect street, corner Sterling avenue, on 1st September.

**Dr. John G. Spenzer** has secured offices in the Rose Building and will move in the 1st September.

**Drs. J. B. McGee and J. H. Belt** left on 21st of August to spend a few weeks in the Adirondacks.

**Dr. and Mrs. Wm. J. Brokaw** returned from a trip down the St. Lawrence river to Montreal, Quebec and the Thousand Islands.

**Dr. Edward S. Lauder** left the latter part of August for a vacation in the Georgian bay region. He will return on 7th September.

**Dr. Lillian G. Towslee** spent two weeks in August enjoying a trip down the St. Lawrence, to the Thousand Islands, Montreal and Quebec.

**Dr. William E. Lower** has been appointed Acting Assistant Surgeon and ordered to join the army in China. He left Cleveland on the 7th August.

**Dr. John Upham** has been appointed to the department of the principles of surgery and clinical surgery in the Ohio Medical University at Columbus.

**Dr. G. Seeley Smith** left on 22nd August on a vacation. The Doctor will visit Boston, Providence and other Eastern cities and then join Mrs. Smith at Falmouth.

**Dr. James Brew**, of Nashville, Tenn., has been appointed assistant to Dr. Birge, the visiting surgeon at Lakeside Hospital, for the service of physicians not connected with the staff.

**The American Association of Obstetricians and Gynecologists** will hold its thirteenth annual meeting in the Assembly room of the Galt House, Louisville, Ky., Tuesday, Wednesday and Thursday, September 18, 19 and 20, 1900, under the presidency of Dr. Rufus Bartlett Hall, of Cincinnati, O.

The following-named papers have been offered:

1. President's address, R. B. Hall, Cincinnati.
2. Ovarian fibroma—case with microscopical report—L. H. Laidley, St. Louis.
3. Cholelithiasis—with report of cases—H. E. Hayd, Buffalo.
4. Appendicitis during pregnancy, Charles G. Cumston, Boston.
5. Diagnosis of ectopic pregnancy before rupture, based on ten cases, J. F. Baldwin, Columbus.
6. Three cases of extrauterine pregnancy, with specimens, W. B. Dorsett, St. Louis.
7. The private hospital, Joseph Price, Philadelphia.
8. Paper (title undetermined), E. F. Fish, Milwaukee.
9. Paper (title undetermined), C. C. Frederick, Buffalo.
10. Extirpation of the rectum and sigmoid per vaginum, John B. Murphy, Chicago.
11. Paper (title undetermined), H. O. Pantzer, Indianapolis.
12. Paper (title undetermined), J. H. Carstens, Detroit.
13. The hymen—of what significance is its presence or absence in determining virginity, John Milton Duff, Pittsburg.
14. Paper (title undetermined), W. P. Manton, Detroit.
15. Paper (title undetermined), F. Blume, Pittsburg.
16. A satisfactory method for suspension of the uterus, Robert T. Morris, New York.
17. Paper (title undetermined), H. W. Longyear, Detroit.
18. Some points regarding surgery of the gall-bladder, A. Vander Veer, Albany.
19. Surgery of the liver and bile ducts, W. G. Macdonald, Albany.
20. Observations respecting malignant diseases of pelvic organs, Augustus P. Clarke, Cambridge.
21. Paper (title undetermined), M. Rosenwasser, Cleveland.
22. Bilateral celiotomy and shortening of the round ligaments for complicated retroversion of the uterus, A. Goldspohn, Chicago.



23. Paper (title undetermined), W. B. Chase, New York City.
24. Paper (title undetermined), Charles A. L. Reed, Cincinnati.
25. Round ligament ventrosuspension of the uterus, D. Tod Gilliam, Columbus.

26. Paper (title undetermined), L. S. McMurry, Louisville.

The titles of papers are announced in the order of their reception. The permanent program will be classified and issued about August 25, after which date no further titles can be added or changes made in the printed program.

A cordial invitation is extended to the medical profession to attend the several scientific sessions of the association.

**According to the Medical Record** the anti-vaccinationists of New York mean to defeat Mr. Roosevelt at the polls in November and will include Mr. McKinley in the same punishment unless they jointly and severally relieve themselves of the charge of complicity in the vaccination of a hundred or so negroes at Stockport, N. Y. This resolution is said to have been effected by some six or seven "strenuous" aunties.

**Signs of Death.** It is not often that the well-trained medical practitioner mistakes the signs of death. It is well, however, to note essential characteristics as a certain means of recognition, as has been recently reiterated by the *British Medical Journal*:

"Syncope, coma, concussion, hysterical spasm, catalepsy and exhaustion may simulate death, although in these conditions the body warmth is retained and the heart and lung action continue, but feebly perhaps. The signs on which a medical man should rely as furnishing the best evidence of the reality of death, prior to the commencement of putrefactive changes, are:

"1. The absence of circulation and respiration.

"2. The gradual cooling of the body, the extremities cooling first and the trunk last.

"3. Gradual supervention of rigor mortis.

"4. The production of post-mortem stains or ecchymoses.

"The careful observation of these four signs by a medical man will enable him to distinguish a living from a dead body."

**When a child complains of pain** in the knee for any length of time, without any evidence of local disease, invariably be on your guard. Nine times out of ten it means that the child has hip-joint disease.

**A Christian Science teacher** defines cancer as "an accumulation of discordant thought."

**The Operating Room at Lakeside Hospital**, which is used by surgeons not members of the staff, is being enlarged and generally refitted.

**According to Mr. Treeves**, Dr. Jameson gives the following instructions concerning the hygienic handling of South African water: "Boil it, strain it, filter it and throw it away."

**Charles Dudley Warner** says that the difference between the "faith cure" and the "mind cure" is that the mind cure doesn't require any faith, and the faith cure doesn't require any mind."

**A Remedy for Sweating Hands.** The *Journal de Medecine de Paris* of December 17, 1899, gives the following formula:

Borax and salicylic acid, of each 4 drachms.

Boric acid, 1 drachm.

Glycerin and dilute alcohol, of each 2 ounces.

Apply with friction three or four times a day.

**The Mayor of Marseilles** put a premium of one cent upon each rat or mouse delivered alive or dead to the authorities. This was done on May 15, and in fifteen days only 686 premiums had been paid. This rate of destruction is not regarded as satisfactory, and experiments are to be made with a communicable disease. The cause of the order against rats was the appearance of plague at Port Said and Smyrna.

**Summer Mortality.** The *Evening Post* recently published the following, dated Albany, July 30th: "An article contained in a bulletin just issued by the state board of health furnishes some instructive data on the subject of summer mortality. The summer months in New York state appear to be the unhealthy season of the year. According to the state board of health's bulletin, the summer months show in addition to a large total mortality a great relative preponderance of mortality from the sometimes called preventable diseases and of deaths in early life. Of the local diseases the deaths reported from diseases of the digestive organs are increased. Diseases of the nervous system have a larger mortality than in the autumn and less than in spring and winter. Consumption has fewer deaths in summer. Cancer showed no material variation. There are fewer deaths from old age in summer. The deaths from accidents and violence are much increased, thirty-three per cent. occurring in these months; the increase is chiefly due to drowning and the effects of heat."

**The Eyesight of School-Children.** Dr. Wallace Pyle, who was commissioned by the Jersey City board of education to examine the eyes of the pupils of Public School No. 1, has submitted a report of his investigation. He examined three hundred and fifteen pupils. Of these only sixty-nine had perfect eyes, and seventy-one of the whole number were in danger of permanent injury because of neglect to provide them with glasses. In the majority of cases the defect was slight and capable of correction by glasses. There were nine cases of trachoma.—*Med. Record.*

**Lepers in France.** It is estimated that there are about four hundred lepers in France, many of whom are missionaries and nurses who have contracted the disease caring for sufferers in distant countries, and also soldiers and officials from the colonies. They are now scattered about in Brittany, in the Pyrenees, on the shores of the Mediterranean, and in Paris, where there are one hundred and fifty. A committee has been formed at the instigation of Dom Santon, a member of the Benedictine community of Liguge, and also a doctor of medicine, to further measures for the care of lepers in France, and to prevent further spread of the disease. Dom Santon has studied leprosy for a number of years in the course of his travels about the world for this purpose, and his plans to deal with the disease in France have received the approval of the French government. He has acquired property in the Vosges, where he purposes to establish an asylum for lepers, to be called the St. Martin Sanatorium.

**Tachycardia Following Enteric Fever.** C. Burland (*The Lancet*) treated two hundred and sixty-five cases of enteric fever on one of the transports returning from South Africa to Southampton. The lowest pulse rate in this series was 72 per minute and the highest was 150, an average exactly of 98.25. In 56 per cent. the pulse rate was 80; in 25 per cent. it was 95; in 10 per cent. it was 100; in 5 per cent. it was 110; and in 4 per cent. it was from 120 to 140. All the cases were in the convalescent stage when seen by the writer, whose attention was attracted by the uniformly rapid pulse rate. He thinks this may have been due to the great privations to which the patients had been subjected previous to their illness. The treatment was simple, consisting of free stimulation with brandy and champagne, while digitalis, carbonate of ammonia, and strychnine were the drugs chiefly relied upon, the latter being administered hypodermically in several extreme cases.—*Medical Record.*



**The State Board of Medical Examiners of New Jersey** on July 5 determined to admit to the practice of medicine in that state the licensees of other state boards, provided that the candidate for such endorsement shall present satisfactory evidence of the academic and medical education required by the New Jersey board, and that license presented for endorsement shall have been issued after a state examination of the same grade and kind as that required by the New Jersey board.

**Recurrent Headaches.** Brunton has found sodium salicylate of great service in toxic headaches. He gives the drug in the dose of 15 to 30 grains of potassium bromid. This will usually prevent the occurrence of the headache in the morning. For violent, persistent or recurring headache he gives the salicylate in small doses three times a day just before or after eating, combined with half a dram of aromatic spirit of ammonia. It may be well in some patients, when giving salicylates regularly, to give them also a little iron to counteract the anemic effects of these preparations.—*Denver Medical Times*.

**Heart Tonics.** Dr. I. N. Upshur, of Richmond, Va., discussed this subject before the Section of Materia Medica and Therapeutics of the American Medical Association as follows: He said that digitalis was an unsatisfactory and uncertain remedy because its action could not be controlled. The same was true to less degree of convallaria. Sparteine was of great service in weak and flabby hearts. Strophanthus was very much superior to digitalis. It was more prompt in its action and more permanent in its effects. When combined with strychnine it was a most valuable agent in fevers and weak states of the system. Atropine was of especial value in cases of cardiac insufficiency accompanied by bronchorrhea. Caffeine was of considerable service when the kidneys were affected. Strychnine was our most valuable and reliable heart tonic. If given before chloroform anesthesia it prevented cardiac failure. It was invaluable in the case of a weak heart from any cause. Nitroglycerin was not a heart tonic. It was contraindicated in weak states of the system, and especially in surgical shock. It was a motor depressant, and its too free use was fruitful of harm. In the late stages of typhoid, opium seemed to have a true tonic effect on the heart. *Cactus grandiflorus* was useful in cases of rapid heart due to tobacco poisoning.—*Medical Record*.

**Ricketts, of Cincinnati, says:** After using iodoform, wash the hands in soap and water, and then rinse them in a little vinegar. This will entirely remove the odor.—*Carolina Medical Journal*.

**Broken Neck.** Louis Vogel, aged twenty-one years, is at the Samaritan Hospital suffering from a fracture of the fourth cervical vertebra. The injury was received July 4th by falling from a tree. Vogel is entirely paralyzed from his neck down, but retains consciousness and is quite cheerful. Liquid food is taken and digested and the man's condition seems to have slightly improved of late.—*Medical News*.

**Holocaine Versus Cocaine in Eye Troubles.** The superiority of holocaine over cocaine in certain respects is fully set forth by Edward Jackson in the February *American Therapist*. Briefly stated holocaine does not dilute the pupil, is slightly antiseptic, quicker in action than cocaine and its use is not followed by reaction and hyperemia. It is especially adapted for the removal of foreign bodies, the prevention of pain from strong astringent collyria, and for such corneal operations as paracentesis and the curetting or cauterization of ulcers. A 1 per cent. solution is generally employed to produce local anesthesia.—*Denver Medical Times*.

**Unconscious Accouchements.** Sr. Guillermo Serra (*La Semana Medica*, May 10th; *Independance Medicale*, July 4th) says that unconscious accouchement is now admitted to be possible even in healthy women, sound in mind and body, and this fact must therefore be borne in mind in legal medicine. Among the most frequent causes are enumerated: multiparity of the woman, abnormally great pelvic dimensions, excessive development and exaggerated irritability of the muscular elements of the uterus, the absence of pains in the early period or even during the entire labor, as well as possible ignorance or misconception concerning pregnancy. In most cases several of these causes cooperate. A frequent factor is the sensation of an urgent need to urinate and defecate during labor, the efforts to satisfy this imaginary need at times inducing sudden accouchement without the woman experiencing any particular impression thereof. The author records a case of this character, in which one child was born in the night-chair, while a second was born immediately afterward on the patient getting to bed. The puerperium was normal. The case of the author's daughter is even yet more

curious. She had conceived while suckling a previous child and did not experience any of the morbid symptoms usual in the early stage of pregnancy. She was quite unconscious of her condition. One night she summoned the author in consequence of abdominal pains which compelled her to keep to her bed. The author prepared a calmative for her; returned home, but hardly had he arrived there when he was again summoned. The patient had pains in the genitalia, but before he could examine her the cry of the infant announced what had occurred. These unconscious accouchements must not be confounded with cases in which labor surprises the woman in the street or in a vehicle. The distinction between the two is of great medico-legal importance—*N. Y. Medical Journal*.

**The Plague.** On August 3d four cases of plague and two deaths from the scourge were reported in London, England. Diagnosis was confirmed by bacteriologic examination. On August 6th a case of the plague was discovered on a vessel in the harbor at Hamburg, Germany. Up to July 14th 300 cases of plague had occurred in Sydney, Australia, of which number 101 died, 51 remained under treatment; ten of the patients were Chinese, of whom eight died. The percentage of recoveries from plague among Europeans in Sydney is very satisfactory, more than half of the number attacked having recovered. As in China, however, the mortality from plague amongst the Chinese in Australia is very high. During the week ending July 23d, 43 cases of plague occurred in Hong Kong, and 44 deaths from the disease. In India cholera and famine are at present attracting more attention than the plague. The last seems waning, but quarantine precautions are none the less imperative.—*Medical News*.

**A New Treatment for Pulmonary Consumption.** Mendel has instituted a new kind of treatment for consumption, which has given him considerable satisfaction. By means of a long, curved syringe of the capacity of a drachm, he injects through the mouth into the trachea about 3 drachms of the following solution:

Oil of eucalyptus, oil of thyme, oil of cinnamon, of each 1 drachm; iodoform, 20 grains; bromoform, 10 drops; sterilized olive oil,  $3\frac{1}{2}$  fluid ounces. The tracheal injection is practised daily. The patient, who feels the solution trickling into his lungs, experiences an agreeable sensation of warmth, and does not cough. In his early experiments, Dr. Mendel operated with a mirror, but



now he is able to dispense with that aid. The patient holds his tongue himself outside his mouth between thumb and finger by means of a napkin. The treatment is simple and inoffensive, and the effects vary with the stage of the disease.

In patients in the first stage he has succeeded after two or three weeks' treatment in relieving the cough and expectoration, and even stopping them altogether; strength, sleep and appetite also return. In the two remaining stages of the malady, the results are not so satisfactory, but still considerable benefit is obtained, expectoration being easier and less abundant, while strength and appetite improve.—*Pharmaceutical Era*.

**Autopsy on King James I.** Mr. Jonathan Hutchinson, F. R. S., in his *Archives of Surgery* for April, says that in the Harleian Manuscript 383, there is a copy of a letter from a Mr. William Neve to Sir Thomas Hollande, concerning the embalment and bringing to town of the body of King James. The writer says: "The king's body was about the 29th of March disembowelled, and his heart was found to be great but soft, his liver freshe as a young man's, one of his kidneys very good, but the other shrunk soe little as they could hardly find it, wherein there was two stones. His Lites and Gall, blacke: judged to proceed of melancholy. The semyture of his head so stronge as they *could hardly breake it open with a chesill and a sawe*; and soe full of braynes as they could not upon the openinge keepe them from spilling; a great marke of his infynite judgement."—*N. Y. M. Journal*.

**Strychnine in Opium Poisoning** is the subject of a communication from Dr. Henry Smith, of Streatham, Eng., who reports the following case: The patient, at least half an hour before being found, had taken 3 oz. of laudanum. The friends immediately gave an emetic of mustard and water. On the arrival of the author three-quarters of an hour later, he found the patient nearly comatose, with all the usual symptoms of profound opium poisoning. A subcutaneous injection of apomorphine was given, which produced free vomiting, the vomited matter smelling strongly of laudanum. The stomach was quickly washed out, but coma continued profound. The subcutaneous injection of atropine sulphate and strychnine sulphate were given alternately and pushed until each produced characteristic symptoms. At the end of seventy minutes after the doctor's arrival the pupils, instead of being "pinhole" were well dilated, and the legs and arms were twitching. The total amount of atropine sulphate given was  $\frac{1}{2}$  grn. (in

five doses of 1-40 grn.) and that of strychnine sulphate 1-10 grn. (in six doses of 1-60 grn.). In the interval between the injections strong coffee was siphoned into the stomach, and friction kept up energetically over the whole body, while warmth was provided by blankets and hot water bottles. At the end of seventy minutes, the patient being still in collapse and unconscious, 1-100 grn. digitalin was given subcutaneously. During the following four hours there was steady improvement; but during the next half hour the pupils became nearly "pinhole" again, and the breathing was slightly stertorous. Two more injections of 1-40 grn. each of atropine sulphate were given at intervals of fifteen minutes, and at the end of another period of three hours the patient was out of danger.—*Merck's Archives*.

**In France** the administration of solid food to infants under one year of age is forbidden by law except upon the advice of a physician.—*Medical Age*.

**The Blind in Russia.** There are more than twice as many blind persons in Russia as in the whole of the rest of Europe. They number 190,000, which is equivalent to two in every 1,000 of the population. In France and England the proportion is not quite one per 1,000.—*Medical Record*.

**To Keep Joints Supple.** As years increase the muscles become stiffer, the joints less supple. Light gymnastics, affecting the whole body, become imperatively necessary if one would retain elasticity, avers a writer in the *Ledger Monthly*.

The Oriental practice of anointing the body, especially the knee joints, is a valuable one. Sweet almond, olive oil and goose grease, perfumed if desired, are good unguents.

If the muscles of the back become tired or weak, a good rubbing with either of these after the bath, will bring a delightful sense of rest and elasticity.

An ointment used by professional dancers is given as follows: The fat of deer or stag, eight ounces; olive oil, six ounces; virgin wax, three ounces; white brandy, one-half pint; musk, one grain; rose water, four ounces. The fat, oil and wax are melted together, the rosewater stirred into the brandy, after which all the ingredients are beaten together.

Besides giving suppleness to the limbs in dancing, it is excellent to relieve the stiffness which follows violent exercise (a boon to bicyclists). Any perfume may be used instead of musk.

**Living on Fifteen Cents a Day.** A Chicago dispatch states that President Harper, of the Chicago University, contemplates trying Miss Katherine Davis' experiment of attempting to live on fifteen cents a day.—*Medical News*.

**A Prolific Birth.** Recent visitors to Atlantic City will recall the aquarium tank on the iron pier and be interested in the event that occurred there this week. A fine seahorse had been captured and placed in the aquarium. During the night it gave birth to 1,000 baby seahorses.—*Medical News*.

**Experiments with the Milk of Tuberculous Cows.** According to the *New York Times* for August 2d, the tuberculosis committee of the state board of health is at present conducting experiments with the milk of a tuberculous cow. This milk is being given to rabbits, which animals are being inoculated with it. Besides the rabbits, some guinea pigs will be inoculated with the milk of the tuberculous cow, and also with human tubercle bacilli, and the result carefully noted. By these experiments it is hoped to ascertain whether the milk from a diseased cow will carry the disease into any animal.—*N. Y. Medical Journal*.

**Mr. Treves on the Conditions of Success in Medical Practice.** Mr. Treves, who has recently jumped from fame into notoriety, in presenting the prizes to the students at the opening ceremony of the additions to the London Hospital Medical College recently, made some excellent remarks which are worth reproducing as cited by the *New York Times* for August 3d from the *London News*. Mr. Treves said that as a student he was signally undistinguished. The idle student was about to present prizes to the industrious students. His sympathies a little went out to his own clique—the idle, unsuccessful majority. He suffered a good deal by the advice tendered to him to mend his ways. He was talked to by persons supposed to have a moral influence with youth, and he had a somewhat bad time. One mentor gave him a copy of Hogarth's *Idle and Industrious Apprentice* series, which was expected to have a good effect upon him. He was impressed by the fact that the idle apprentice seemed to have an exceedingly good time, passing through exciting periods and going to sea, whereas the existence of the industrious apprentice seemed to be one of unmitigated dullness. When the former reached about the time of life to which he (Mr. Treves) had now attained, he had the misfortune to be hanged at Tyburn, whereas the latter, at the same period, became lord mayor of London. It was hard to say in which direction one's sympathies ought to go,



and which end was to be preferred. One of the most encouraging remarks made to him at the commencement of his career fell from the then consulting surgeon of the hospital. Referring to a surgeon then enjoying great fame, he said: "I don't see why you should not do as well as he has done, because at your age he was a perfect fool." That made him extremely happy. Unsuccessful students often used arguments that he hoped to be able to confute. One of them was, "I can't get on; I have no luck." So far as their profession was concerned, there was no such thing as luck. Luck meant that a man was ready for a certain chance when it came along.

The same circumstances befell twenty men, but only one was prepared to take advantage of them. Some students complained that they had no genius. Genius, he supposed, was some sort of neurosis—an uncalculated nervous disease. The few men of genius he had met had been exceedingly impossible persons. They would certainly be entirely out of place in the medical profession, where even cleverness was not to be encouraged. Indeed, of all desperately dangerous persons, the brilliant surgeon was the most lamentable. Cleverness found its proper field, not in the operating theatre, but at the Egyptian Hall. Again, it was said: "I cannot succeed; I have no influence." No person succeeded better than the man who stood entirely upon his own feet, depending on no one to assist his progress. The absence of means was another ground of lamentation; but the men who had succeeded most conspicuously were the men who started on nothing. The things that made for progress were difficult to define. Hard work came first. Then there must be close observation. Of course, too, a man must know his profession. As Sir William Jenner put it, "He must be in a position to be dogmatic." There were two classes of dogmatic persons—those who knew everything and those who knew nothing of a subject. Again, a man must be kind. It was not kind to blurt out to a lady the news that she had a malignant disease. The last quality he would mention as necessary to a successful medical man was honesty, and it could not too emphatically be laid stress upon. The late Sir Andrew Clark was a man who had no knowledge of dullness, and an infinite capacity for work. He was a particularly shrewd observer, amusing in his dogmatism, a man than whom none had a kindlier heart, and almost pedantically honest. Sir Andrew started without money, friends or influence, and he rose to the highest position in his profession.—*N. Y. Medical Journal*.

**Triplets and Taxes.** According to the *New York Times* for August 2d, an immigrant recently endeavored to conceal his triplets at the Barge Office. Every one knows that triplets are a tax upon their parents, but this couple feared that there would be a tax upon the triplets.—*N. Y. Medical Journal*.

**Infant Feeding.** After the first two days the infant should be fed at regular intervals of two hours, and from one to one and a half ounces at each feeding. About the third month the intervals should be lengthened to two and one-half hours, feeding three and one-half ounces each time. The intervals should be constantly lengthened, until at the ninth to the twelfth month feeding should be three and one-half hours apart, and seven to nine and one-half ounces in quantity. Until the sixth week two feedings during the night should be allowed; one from the sixth week to the sixth month, when all night-feeding should be discontinued.—*Rowell*.

**British Army Investigating Commission.** It is reported that one of the stormiest scenes of the present session of the Commons occurred last Monday evening, when Mr. Bartlett Burdett-Coutts demanded greater powers for the Hospital Commission to investigate the management of the military hospitals in South Africa. He declared that the truth would not be learned under the present plan of investigation, as the soldiers would be afraid to testify. Mr. Balfour, government leader, in the course of a bitter reply, accused Mr. Burdett-Coutts of "maligning the character of the British army," and sneered at what he called "the honorable member's evident nervousness as to the result of the inquiry."—*Medical News*.

**The Xiphopagous Twins.** On May 30, 1900, Dr. Chapot Prevost, of Brazil, separated the twins which have been the subject of much medical discussion during the past year. It will be recalled from the descriptions that have appeared in our columns that they were not united by a single band as were the Siamese twins, but their abdominal cavities were connected by a large opening, practically forming one cavity, and the thoracic cavities were also implicated, while the livers were united to nearly their whole extent. On the seventh day after the operation one of the twins died, the other continued to improve without any drawback. An autopsy revealed a state of inflammation of the pleura and pericardium with exudation, while the liver was completely healed.—*Medical News*.

**Artificial Light and the Eyes.** In a German photographic magazine it is stated that the conclusion has been reached by a Russian physician that the electric light is the least injurious to the eyes and that candle-light is the most harmful. He has observed the number of times that the lids are closed under otherwise similar conditions, and states that the oftener the lids are closed the greater the fatigue and consequent injury. As a result of his experiments he compiled the following table showing the number of times a minute the lids were closed with different illuminations: Candle light, 6 4-5; gas, 2 4-5; sun, 2 1-5; electric, 1 4-5.—*Medical News*.

**The Dangers of Celluloid Articles of Wearing Apparel.** Many instances of the dangers of celluloid combs, etc., are on record, but, according to the *New York Times* for August 6th, a motorman at Waukesha, Wis., has added a novel one to the list. While he was handling a burned-out motor, the controller came in contact with a celluloid collar which he was wearing. In a moment his neck was encircled by fire and he was severely burned. Celluloid is too inflammable a material to be safe to wear in any form, and especially for those whose vocations keep them in contact with fire or electrical currents.—*N. Y. Medical Journal*.

**Carbolic Acid** is responsible for a considerable number of "accidents" now that its use has become general in the household. Peculiar interest is attached to a case related by Dr. C. H. L. Johnston, of St. John, N. B., of an inebriate who, being on one of his periodical outbreaks, returned home, saw a bottle of what he supposed to be beer, put it to his mouth and drank the contents. The bottle contained an ounce of carbolic acid in liquid form, or ninety per cent. of the pure acid, mixed with several ounces of paraffin oil such as is used for illuminating, and which the women of the family were using for sanitary purposes. When his friends discovered what the man had taken they gave him an emetic of mustard and warm water and sent for the doctors, who saw him soon afterward, when he was vomiting, and had evidently got rid of the poison. There was no erosion on the lips, mouth or throat, and he recovered without a bad symptom, a result probably due to a modifying influence on the part of the paraffin oil.—*Merck's Archives*.



**Counter-Irritants.****The Doctor's Dream.**

Last evening I was talking  
With a doctor aged and gray,  
Who told me of a dream he had  
I think 'twas Christmas day.

While snoozing in his office,  
The vision came to view,  
For he saw an angel enter,  
Dressed in garments white and new.

Said the angel, "I'm from heaven,  
The Lord just sent me down,  
To bring you up to glory,  
And put on your golden crown.

"You've been a friend to everyone  
And worked hard night and day,  
You have doctored many thousands,  
And from few received your pay.

"So we want you up in glory,  
For you have labored hard,  
And the good Lord is preparing  
Your eternal, just reward."

Then the angel and the doctor  
Started up toward glory's gate,  
But when passing close to hades,  
The angel murmured "Wait."

"I have got a place to show you;  
It's the hottest place in hell,  
Where the ones who never paid you  
In torment always dwell."

And, behold, the doctor saw there  
His old patients by the score,  
And grabbing up a chair and fan,  
He wished for nothing more:

But was bound to sit and watch them,  
As they'd sizzle, singe and burn,  
And his eyes would rest on debtors  
Whichever way they'd turn.

Said the angel, "Come on, doctor,  
There's the pearly gates I see,"  
But the doctor only muttered,  
"This is heaven enough for me."

He refused to go on further,  
 But preferred to sit and gaze  
 At that crowd of rank old deadheads,  
 As they lay there in the blaze.

But just then the doctor's office clock  
 Cuckooed the hour of seven,  
 And he awoke to find himself  
 In neither hell nor heaven.

—*Medical World.*

A blind carpenter took his hammer and saw. A dumb wheelwright picked up a hub and spoke. To which may be added that a deaf farmer drove in his flock and herd.—*Boston Transcript.*

Miss E. M. Merrick, the portrait painter, was once urged by an old village dame to paint the portrait of her soldier son, who was serving in India. She added she was very proud of her boy, as he was one of the "rals." Miss Merrick asked what that was. "Oh," explained the old woman, "he was either a gene *ral*, or an admi *ral*, or a corpo *ral*; but I'm not quite sure which it is."

*Curate*: "So sorry to hear your husband's met with an accident, Mrs. Snape." *Mrs. Snape*: "Yes, sir, 'e's very bad, pore man. 'E wur workin' on the railway line th' other day, 'an a engine come along an' run clean over 'is pare leg; an' now 'e'll be laid up abed for weeks. It's what I b'lieve the doctors calls locomotive attacks ye."—*From Punch.*

At a diplomatic dinner in London early this season, where Ambassador Choate was a guest, the conversation turned to Alaska and the Klondike. A high state official, speaking of the Canadian demand for a port of entry, inquired, "I wonder if they will make it hot for you up there." "I wish they would," gravely responded Mr. Choate; "it is just what the territory wants."

The Scotch people have always been particularly happy in what might be called the ready retort,—an answer not only witty, but wise,—says the *Detroit Free Press*. Take the exquisite humor of the old maiden lady of Montrose, who, when asked to subscribe to a volunteer corps fund in that town, replied: "Indeed, I'll dae nae sic thing! I ne'er could raise a man for mysel, and I'm no gean to raise men for the king."

An old army officer, according to Mrs. Custer, had a 4-year-old boy who never tired of war stories. "The story is a little rough on me," said the officer to Mrs. Custer; "but, if you know a child, you know that he wants a plentiful sprinkling of 'I's' and nothing told in the third person. So I kept on as he demanded, till one day he looked up in my face, and said, 'Father, couldn't you get any one to help you put down the Rebellion?'"

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## Original Articles.

### THE CURE OF HERNIA BY SURGICAL MEANS.

BY CHARLES B. PARKER, M. D., CLEVELAND.

Professor of the Principles and Practice of Surgery, Cleveland College of Physicians and Surgeons.

The cure of hernia by surgical interference as practiced at this time furnishes a good illustration of the wonderful development of surgery within the last twenty years. When I began my studies the successful treatment of a case of strangulated hernia was received as a triumph, and the surgeon was accorded great credit for his skillful treatment, and yet in none of these cases was any effort made to close the opening, or to perform any operation beyond the mere relief of the strangulated intestine and its return into the abdominal cavity. The methods of asepsis have made the wonderful progress, in the surgical cure of hernia, possible, and a death, or even a failure, is now rarely noted. The literature of the subject is so voluminous that it would be far beyond the limits of my time or your patience to enter into a historical sketch of the operation, or to attempt even a brief description of the many methods now practiced successfully by various surgeons for the radical cure of hernia. I confess that the method of operation which I advocate is the result of my observation and experience. I make no claim for originality, as it is the methods of different operators, which have proven in my experience to give the most certain and satisfactory results.

Formerly the operator sought to avoid opening the hernial sac, therefore he knew his anatomy of hernia layer by layer. We now always open the sac and have no need to make the same careful dissection of the various anatomical layers. But it is well to



have certain anatomic landmarks. The cremaster muscle furnishes this most important guide to the operation in inguinal hernia. The fibers of this muscle can be clearly and distinctly seen, and when the dissection has been carried down onto the muscle, we know that just beneath the muscle and the thin transversalis fascia lies the hernia sac.

I cannot pass the subject of the anatomy of hernia without at least a word. The inguinal canal and its rings exist only in name. The external ring is a slit in the apponeurosis of the external oblique muscle and its columns are in close apposition over the spermatic cord and its contents. The internal ring is a funnel-shaped opening in the transversalis fascia and placed midway between the pubes and the anterior superior spine one-half inch above poutpart ligament. In many cases it is placed higher and more externally. The inguinal canal is  $1\frac{1}{2}$  inches long in the adult, though in the foetus it is much shorter. Surgically considered the inguinal canal has but a floor formed by the union of the transversalis fascia with poutpart ligament, and a roof composed of the apponeurosis of the external oblique. It invests snugly the spermatic cord and its contents.

*Classification.* Hernia may be classified clinically as reducible, irreducible, incarcerated or obstructive, and strangulated. The names, reducible and irreducible, sufficiently indicate the character of these varieties of hernia. An incarcerated hernia may be defined as one in which there is an obstruction to the passage of the intestinal contents. A strangulated hernia is an incarcerated hernia plus an arrest of the circulation within the wall of the intestine as well.

*Diagnosis.* The diagnosis of hernia is often sufficiently evident to the senses; the presence of a tumor in one of the hernial regions with pain and a sense of weakness in the part, the nausea, possibly vomiting, at its first appearance, with a history that the tumor disappears on lying down, and reappears on his taking the erect position, that it has existed for a number of years,—all these points render the diagnosis of reducible hernia extremely easy. If a hernia has existed some years, has gradually increased in size until it is quite large, filling the scrotum, never entirely disappearing when the patient lies down, and is accompanied by a dragging pain and sense of weakness, the diagnosis of an irreducible hernia is made. We have all of the above symptoms intensified in an incarcerated or strangulated hernia, the pain is often severe and sickening, vomiting is at first violent and later persistent, but with-

out so much effort or disturbance, the patient inclining his head to one side and ejecting several mouthfuls of a foul-smelling fluid which stains the linen deeply. The vomited matter at first contains materials from the stomach, then later from the upper part of the small intestine, and finally from its lower portions, and is known as stercoraceous vomiting. Although the odor is foecal and abominable the strangulation is usually in the ileum and real feces do not form so high up. A thready pulse, subnormal temperature, cold perspiration, anxious expression of countenance, and other evidences of profound shock make the diagnosis of incarcerated or strangulated hernia certain. An obstructed hernia may come on quite gradually, and continue for some time without causing extreme symptoms or the death of the bowel. A strangulated hernia, on the other hand, develops suddenly, progresses rapidly with aggravated symptoms, and in a few days—three to seven—the vitality of the bowel is destroyed.

But in some cases of hernia, no tumor is visible. I recall two such patients particularly; one was a man, the other a woman, and both of them exhibited symptoms of an acute, intestinal obstruction. No hernia was visible. Neither patient had ever suffered from hernia; there was no history of violent effort which so often induces hernia, and the pain was referred indefinitely to the abdominal cavity. Following the rule, which is a good one I think, of examining every case of intestinal obstruction carefully for the possibility of hernia, it was found that the resistance of the femoral ring in both these cases seemed more pronounced on one side than on the other, and on the strength of this symptom alone an operation for hernia was made, and in each case a femoral hernia discovered and relieved. Hernia, then, is a possibility in each patient exhibiting symptoms of intestinal obstruction, and should be absolutely eliminated before the abdomen is opened.

*Indications for Operation.* Not every case of hernia requires operation. In reducible hernia, where the patient can wear a truss with comfort, and without inconvenience to him in the performance of his necessary duties, operation for hernia is superfluous.

In irreducible hernia an operation is usually indicated. The fact that the hernia is almost sure to increase in size, the pain and dragging and weakness, associated with the presence of the hernia, diminishes very much the patient's ability to do his full share of work, and these become indications for operation.

In obstructed and strangulated hernia operation is indicated, and should be performed as soon as the diagnosis has been made. In children under four years of age, unless the hernia is strangulated or incarcerated or irreducible, operation is to be avoided, for it has been found that a large proportion of these cases recover within the first three or four years by the application of a suitable truss.

*Preparation of the Patient.* If the case is not one of incarcerated or strangulated hernia, it is well to have the patient in bed a few days before operation, in which time the bowels can be regulated, and the diet as well. It is best to give cathartics the second evening before operation, and a simple enema the evening preceding operation. Copious draughts of water during the day before operation relieve the patient of the continuous sense of thirst. After a bath and shaving of the pubes, and thorough disinfection with a bichloride solution of 1-1000, a soap poultice is applied for the night over the seat of operation. This is made by chipping "ivory soap" into the least possible quantity of water to cover it and letting it stand for a few hours until reduced to a paste, which is applied one finger thick between two pieces of absorbent gauze. It is very penetrating though non-irritating, and facilitates the subsequent scrubbing and disinfection that is to take place just preceding operation. The great advantage over the moist bichloride pack is that it is never attended by any rash, which so often follows the use of mercurial solution.

*Suture Materials.* Chromatized catgut No. 1 for the sac and transversalis fascia, chromatized kangaroo tendon for the internal oblique muscle and poupart's ligament, and a continuous kangaroo suture for the aponeurosis of the external oblique. Chromatized catgut may be used instead of the kangaroo for the same purposes. No. 1 chromatized catgut is used for the cuticular stitch. Some three years ago I made use of silver wire where I now use kangaroo tendon. The cases treated with the silver wire usually healed promptly, but some months later, in a few instances, inflammation occurred and a sinus formed. This sinus invariably led down to a silver wire stitch. When the wire had been removed the sinus quickly healed. In no case did (all) of the silver wire stitches suppurate, and their removal seemed to have no unfavorable effect upon the final cure. The patient in whom one or two stitches had been removed remained just as completely cured as those in whom healing by first intention had taken place. The number of successful cases reported in which kangaroo has been used is now so



large that there can be no doubt that this is the best material for the buried suture which we now possess.

*Anaesthesia.* When not contra-indicated by the physical condition of the patient a general anesthetic should be used. Should the patient's condition make the administration of a general anesthetic dangerous, the operation can be safely performed under local anaesthesia. For the cutaneous incision Schleich fluid may be used. When the aponeurosis of the external oblique is opened the ilio-inguinal and the genital branch of the genito-crural nerve generally appear united in a single trunk, lying upon the lower border of the internal oblique muscle. Cocain solution in 4 to 10 per cent. introduced into the joint trunk high up will render the subsequent steps of the operation nearly painless. The intestine can be handled and manipulated and even cut without pain. Any drawing or dragging on the intestine, however, will produce colicky pain at once. If this dragging is avoided no pain from the necessary manipulation of the bowels will occur. No cocain is to be applied directly to the intestinal surface. In a case of advanced Bright's disease I made the operation for hernia in a woman without my patient complaining once of pain. I think in cases of strangulated hernia, where the operation must be done at once without an examination of the urine and just after a meal or in a patient who is suffering from a cold, the local anesthetic rather than a general anesthetic could be more safely used.

*Incision.* Although in the majority of cases I have employed the straight incision parallel to and three-fourths of an inch from Poupart's ligament, I believe the suggestion of Senn of making a flap incision to be a good one. Certainly it is the best form of incision in many operations, and has the advantage of placing the cutaneous wound, which is so liable to become septic away from the line of the deep sutures. It also gives a wider field for operation. The disadvantages are that some of the more important nerve terminals are divided, and the incision is somewhat longer. I have accomplished the same result by making a straight incision half an inch above the future line of deep sutures, down to the aponeurosis of the external oblique, with retractors this flap can be reflected beyond Poupart's ligament, and when finally brought into apposition at the end of the operation, the line of incision is sufficiently removed from the line of deep sutures. Whatever superficial incision is chosen, it should be made far enough outward so as to completely expose the internal abdominal ring when the deep dissection is completed. This

important point is to be kept in mind throughout the operation, that it is the internal abdominal ring that is to be closed. Having made the superficial incision down to the fascia over the external oblique, and having reflected it, the next step is the division of the aponeurosis of the external oblique muscle. This can be made upon a grooved director, or with a pair of blunt scissors carefully introduced at the external ring. In any case the fibers of the aponeurosis should be divided in their parallel axis, and great care be taken to include nothing but the aponeurosis of the muscle in the incision.

The inguinal canal and its contents are now exposed, the cremaster muscle appearing in front. With catch forceps holding opposite sides of the aponeurosis, it is dissected upward until the white aponeurosis of the rectus muscle appears, and is carried forward towards the median line until the conjoined tendon of the internal oblique and transversalis is disclosed. The dissection is carried downward until the sharp border of Poupart's ligament is exposed for the full length of the incision. Up to this point the surgeon has had no thought of the hernial sac, knowing full well that when the aponeurosis of the external oblique has been divided and the cremaster muscle severed, the hernial sac would be exposed before him. The sac is now opened, its contents noted, and any adhesions of the contents to the sac severed.

In strangulated hernia the opening and inspection of the sac is a most important step in the operation. If the fluid in the strangulated sac is clear, if the endothelium covering the intestine is intact, if the knuckle of strangulated intestine retains its luster, no matter what its color may be, and its endothelium cannot be detached by brushing over it with the handle of the scalpel, it is safe to conclude that the intestine is viable, and may be safely returned into the abdominal cavity. If the fluid within the sac is turbid, and when dropped upon a white towel gives a central stain with nearly colorless border, if the knuckle of intestine is lusterless, its endothelium detached in patches and easily rolled up on the slightest touch with the gauze sponge or scalpel, there is great likelihood that the constricted intestine is dead, and that its return into the abdominal cavity would be attended with disastrous results. It is often necessary in old irreducible herniæ, and occasionally in strangulated herniæ, to remove the portion of omentum included in the hernial sac.

It is very important in this step of the operation to ligate only the vessels, as the practice of ligating the vessels with the fat

*en masse* is often followed by fat necrosis which increases the danger of subsequent infection. As each blood-vessel in the mesentery is divided, it should be grasped singly with fine artery forceps and ligated with chromotized catgut; thus each vessel in turn should receive its ligature. If this is done, one danger of subsequent infection is avoided.

Being assured now that the sac is empty, its treatment becomes the next step in the operation. We are now at the point where the actual weakness in the abdominal wall exists. Every conceivable manipulation has been suggested and practiced upon the sac. It has been invaginated, twisted, pleated, and it has been anchored. Special stitches have been introduced, all to prevent as far as possible the recurrence of the hernia. Nearly all the methods of treating the sac leave a conical depression in the peritoneum. In closing the sac I always place my continuous ligature so that when the sac returns into the abdominal cavity, the ligature shall no longer correspond to the anatomical position of the ring. With two or three artery forceps making considerable traction on the sac, I grasp it at one side, usually the front. The sac having been thoroughly freed on all sides from the internal ring, is thus drawn forward; and a continuous ligature of chromotized catgut applied. With the completion of the stitch the forceps are removed, the peritoneum, which has been put upon the stretch is forcibly withdrawn into the abdominal cavity. The line of suture in the sac as it is placed upward and to one side is carried forward and rests against the firm abdominal walls. With a curved needle and white catgut the transversalis fascia is now gathered up and united in a running stitch. The union of the fascia is a most important step in the operation. I have found it to vary greatly in different patients. In some it is as plainly defined as the fascia of the external oblique; in others it is so thin and delicate that it is difficult to manipulate, but in every case it should be sought for, and an attempt made to close it.

The greatest difference of opinion has existed among operators as to the proper treatment of the spermatic cord, and it must be admitted that the brilliant period of the cure of hernia by surgical means began with the general adoption of Bassini's method of operating—a method with which you are all familiar. Many of the modifications that have been suggested since Bassini's time consist in varying the position of the cord. Halstead depresses the cord into the abdominal muscle. Fowler gouges out a groove in the pubic bone for the cord. The success that has attended



these various modifications is due to the care exercised in closing the ring by sewing the internal oblique muscle to Poupart's ligament rather than the technique used in the transplantation of the cord. These extensive displacements must necessarily expose the patient to the danger of interference with the vitality and functions of the spermatic cord. I have operated with good success after the Bassini method, and after Halstead's, and after Kocher's, but as I have gathered clinical experience it has seemed to me that the correct principle of operation was to disturb the natural anatomical relations of the cord as little as possible. To make the same complete and compact closure of the internal abdominal ring as in the Bassini operation is safer, because in this way we accomplish the best results without the danger of constriction of the cord and atrophy of the testicle. Since adopting this method I have had the most satisfactory results. The cord, then, is not drawn up as in Bassini's method; it is merely depressed firmly against the pubes.

The internal oblique muscle is sewed firmly to Poupart's ligament throughout the whole extent of the internal incision, beginning one inch exterior to the internal abdominal ring, and continuing the interrupted suture down, so that the last suture passes through the conjoined tendon over the cord and through Poupart's ligament, closing the canal firmly and completely. These sutures are made with kangaroo tendon. The aponeurosis of the external oblique muscle is now brought together by a continuous suture of fine kangaroo or chromitized catgut, and union of the skin and superficial structures by a continuous cuticular stitch completes the operation. The wound is sealed with iodoform collodion and a strip of iodoform gauze. This is to be carefully done at the internal extremity of the incision, so that by no possibility any urine, or other impurity may infect it. A voluminous gauze and cotton dressing is applied.

In order to secure absolute rest, I have adopted a rule of fixing the pelvis and hips. In children this is done by applying a plaster cast, and in adults I often use plaster of paris, or a long splint, such as is used in fractures of the shaft of the femur. Absolute rest is most important in securing immediate and complete union of the parts. The presence of the bacillus coli communis in the near-by intestine, the difficulty of protecting an extensive wound in this part of the body, the danger of infection from carelessness in urination, all render the successful carrying out of the operation and the healing without any suppuration, as a

fair test of the operator's aseptic methods. The first dressing, including the plaster or the splint, is allowed to remain unless there is a marked rise of temperature, for at least eight to ten days. In the case of children, I replace the plaster cast and allow it to remain until the second dressing. In the case of adults, when all goes well I remove the splint at the end of ten days. The patient is allowed to be up at the end of three weeks. I do not attempt to adjust a truss, and I request the patient to report at once if there should be any evidence of a giving-away of the scar, and advise him not to lift heavy weights for at least three months.

As we have seen the indications in every operation for inguinal hernia are: 1st. Close the sac. This is accomplished by pulling down the sack and sewing it so that when it retracts it will rest against the abdominal wall. 2d. To close the internal ring by sewing together the transversalis fascia and securing a firm union of the internal oblique and the transversalis muscle to Poupart's ligament. 3d. The displacing the cord on to the pubes and uniting the pillars of the external ring closely over it. 4th. The operation is not to interfere with the functions of the cord or testicle. No veins are removed. No tension is put on the cord and atrophy of the testicle should not occur.

## A CASE OF PYLORIC STENOSIS WITHOUT DILATATION—OPERATION—CURE.\*

BY L. B. TUCKERMAN, M. D.

Visiting Physician to St. Alexis Hospital.

Bertha B., 30 years of age, married, never pregnant, came under my care October 6th, 1899, for persistent vomiting. Her mother died of rheumatism, otherwise the family history was negative. Menses began at 19 years, coming every three weeks, the flow lasting about eight days.

From her childhood she had suffered with her stomach, the attacks coming on with pain referred to the epigastrium, followed by vomiting of intensely sour material. Latterly these attacks had come with increasing frequency, so that for a year or so she had been unable to eat a full meal with comfort, and for the last three weeks she had taken nothing but diluted milk. The lower border of the stomach was about two inches above the umbilicus; and, full or empty, its contour showed clearly through the thin abdominal walls, and its peristalsis could be plainly seen.

\*Read before the Ohio State Medical Society, May 10, 1900.

Physical examination was otherwise negative, except that the patient was pale and emaciated. Bowels were almost constantly constipated, though there were occasional attacks of diarrhoea.

The stomach was washed out and an attempt was made to find a diet which could be assimilated without distress. Eating would be inevitably followed by pain, continuous and increasing until relief came by vomiting. Previous to vomiting, about a quart of sour fluid could be pumped out; acid 45, and containing no lactic acid, but free hydrochloric acid, with sarcinae and torulae in abundance. She was having a gastric hemorrhage when I first saw her, but that ceased in a few hours. The only food which she appeared able to retain without distress was white of an egg, beaten up with lime water and frozen. Any variation from this diet was followed by the old symptoms, excruciating pain in the epigastrium, and heartburn, until vomiting gave temporary relief. During lavage the stomach could be distended so as to hold about a quart. The diagnosis of pyloric stenosis being clear, the absence of tumor and the presence of free hydrochloric acid rendering it probable that the stricture was benign in character, the results of lavage and of dietary restriction having proven wholly unsatisfactory, and the patient being bedridden most of the time, she consented to operation.

December 20th, at St. Alexis Hospital, she was anesthetized with the Latta mixture (nitrate of amyl two drops, chloroform one ounce) and the triple operation, gastro-jejunostomy, jejuno-jejunostomy, and jejuno-plication, was performed.

While going under the anesthetic, she vomited considerable sour material. The pylorus was found rigid and contracted, but there was no appearance of neoplasm. The mesenteric glands were larger than normal. The stomach was not dilated, on the contrary, its muscular walls were greatly thickened and the viscus was in a state of tonic contraction, which made it hard to hold without the abdominal cavity for suture. Indeed, just as the anastomosis with the jejunum was completed, there was a contraction so forcible that the peritoneum, toward the cardiac end of the stomach, where an assistant was holding it with a layer of gauze to keep his fingers from slipping, was stripped off, and considerable time and a number of stitches were needed to repair it.

The patient had but little shock after the operation, but on the evening of the second day she went into a collapse and vomited blood, probably from the old ulcer which had bled before at the time of my first visit. The house surgeon, Dr. Manly, how-



ever, promptly injected into the median cephalic vein 500c. c. of normal salt solution, and gave hypodermically a 20th of a grain of strychnine, and the patient rallied and went on to an uninterrupted recovery. Four days after the operation, she was taking liquid diet freely; a week after the operation she was taking light diet with impunity, two weeks after the operation she could eat anything, and suffered no inconvenience whatever, except from the sacral bed sore, which had begun to develop before she had come to the hospital. By three weeks after the operation, so astonished were her liver and kidneys at the amount of raw material with which she was supplying them for secondary assimilation, that they resented it with a sharp attack of rheumatism, requiring specific treatment. She promptly recovered from the rheumatism, the ulcer healed in due time, and during the ten weeks subsequent to the operation, she gained 38 pounds in weight, was of good color, and was apparently as well as anybody need be.

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REMARKS UPON THE POST-OPERATIVE TREATMENT; WITH ESPECIAL REFERENCE TO THE DRUGS EMPLOYED IN 114 CONSECUTIVE, UNSELECTED ABDOMINAL SECTIONS WITHOUT A DEATH.

BY HUNTER ROBB, M. D.

Professor of Gynecology, Western Reserve University; Gynecologist-in-Chief, Lakeside Hospital, Cleveland, Ohio.

Nearly every patient is restless and suffers more or less pain during the first 24 hours after an operation. Not every complaint, however, must be met with drugs, and a skilful nurse can do much to relieve many of the little discomforts of which the patient is acutely sensible. If, in spite of our efforts, the patient continues to be very restless, especially at night, the administration of an enema consisting of 2 oz. of the milk of asafœtida, to be repeated in an hour, if necessary, is often efficacious. Sometimes half a drachm or a drachm of the bromide of potassium may be combined with the asafœtida. This latter prescription may also be repeated if necessary in an hour or two. If the restlessness still persists, or if the patient suffers severe pain, it may be necessary to give morphine in doses of one-sixth to one-fourth of a grain, which may be repeated or not, according to the effect produced. Morphine, however, should never be used unless other measures have been tried and have failed. It is much better to encourage

the patient to control herself and to bear the pain, telling her that it will not last many hours, and that she will be in every way much better if she can endure it for a short time longer without taking medicine for its relief. The routine employment of morphine is to be condemned. The healing always proceeds better without it, and there is little doubt that the surgeon is often directly responsible for the formation of the morphine habit. Unfortunately, the practice of giving this drug, as a matter of routine, after operations is apparently becoming more and more widespread. It is popular, because it affords immediate comfort to the patient and to those around her. It is not an infrequent practice of surgeons to keep their patients under the influence of morphine for the two or three days subsequent to the operation. Its use is occasionally a necessity, but in the vast majority of cases I feel sure that a patient does not require any sedative at all after an operation, especially if we enlist on our side her own moral support. The danger of using morphine for an extended time after operations lies in the fact that after a short while the patient not only feels the necessity for its repeated use, but is also much more difficult to manage; she becomes restless and fretful, complaining loudly of the most trivial suffering, and her *morale* suffers so much that in some cases the mind may even become unbalanced. In the after-care of over 1,000 abdominal sections, only rarely have we found it necessary to give a dose of morphine, and even then in some of the cases in which it was given there was more than once occasion to regret its employment. We do not, therefore, use opium or any of its derivatives as a routine measure for pain following an operation and always try other procedures before resorting to morphine. In those cases, however, in which the pain is excessive, and in which we have failed to afford relief by carrying out other simpler procedures—such as the giving of a drop of the tincture of capsicum in a teaspoonful of hot water every half hour for two or three doses, or the changing of the patient's position—we order 15 to 20 drops of the deodorized tincture of opium to be added to the nutritive enemata which the patient receives as a routine after the operation. As a rule, where the suffering is intense, this dose will give relief within a short time. In exceptional cases, however, it may be absolutely necessary to administer a hypodermic of morphine.

In this series of cases 18 patients received deodorized tincture of opium by rectum in from 10 to 20 drop doses. The total amount received by the 18 cases was slightly over five and a half

drachms. Thirteen cases received hypodermic injection (gr.  $\frac{1}{8}$  to  $\frac{1}{4}$ ) of morphine. The total amount given in all (13) cases was three and a half grains. While not using morphine as a routine we do not go to the other extreme, but whenever the patient cannot be relieved in other ways, we administer a sufficient amount of morphine to make her comfortable.

We employ the sulphate of strychnine as a routine after every abdominal operation. The patient is given gr. 1-30 by the rectum before she leaves the operating room. When she arrives in the ward she is given strychnine (gr. 1-30) hypodermically with atropine sulphate (gr. 1-75) every half hour for two doses. After this she is then given strychnine (gr. 1-30 to 1-60) hypodermically every 3 to 6 hours, according to the character of the pulse. If there is a condition of marked shock present the strychnine (gr. 1-30 to 1-60) is administered hypodermically every half hour in doses until 6 to 8 doses have been employed. In this manner we believe that we are able to prevent or lessen the condition of shock which sometimes follows a prolonged abdominal operation. If the pulse on the morning after the operation is under 110 as a rule no strychnine is given, but if the pulse is over 120 to the minute, strychnine (gr. 1-40 to 1-30) is given hypodermically every 3 or 4 hours until the pulse rate is reduced. In 113 cases strychnia was given hypodermically, the total amount in the whole number of cases being 32.8 grains, the average amount being 3-10 of a grain. It is only rarely that we use nitro-glycerine.

For the tympanites which sometimes occur after abdominal operations, the tincture of capsicum—one to two drops in a teaspoonful of hot water every half hour for 3 or 4 doses—or 15 to 20 drops of the essence of peppermint will often prove effectual. A turpentine stupe, or a mustard leaf, over the epigastrium is a useful adjuvant. If these measures do not relieve the tympanitic condition a rectal tube is introduced high up into the rectum and allowed to remain for from 15 minutes to half an hour longer, or until the tympany disappears.

The following is a list of the operations included in this series of cases:

(All the operations but one were performed at Lakeside Hospital.)

Appendectomy .....	24
Colporrhaphy, Anterior.....	2
Dilatation and Curettement.....	67
Dilatation with vesical balloon (under anesthesia) ..	1



Fibro-adenoma of Breast, Removal of.....	1
Hemorrhoids, Removal of.....	2
Hysteromyomectomy .....	3
Herniotomy .....	3
Igni-puncture of ovaries.....	36
Myomectomy .....	7
Omentum, Resection of portion of.....	5
Ovaries, Resection of.....	15
Pelvic adhesions, Separation of.....	46
Perineorrhaphy .....	17
Peritonitis, Tubercular, drainage.....	1
Removal of Cervical Polyp.....	1
Removal of piece of cervix for diagnosis.....	1
Salpingectomy (single) .....	6
Salpingectomy (double) .....	1
Salpingo-oophorectomy (single) .....	24
Salpingo-oophorectomy (double) .....	46
Sebaceous Adenoma of Labium Majus.....	1
Suspension of uterus.....	42
Trachelorrhaphy .....	8
Vaginal puncture .....	1

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Total number of individual operations.....361

The total number of individual operations greatly exceeds the actual number of patients from the fact that a single patient often presented several distinct pathological conditions.

Total number of cases in which the abdomen was opened, 114.

Abdominal operations alone.....	56
Abdominal and plastic operations combined.....	58
Appendix vermiformis removed.....	24
Adherent vermiform appendix separated.....	6
Myomectomies .....	7
Myomatous tumors removed in above myomectomies.	16
Suspension of uterus with separation of light adhesions, (this case was operated on under cocaine anesthesia) .....	1

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## APPENDICITIS IN A CASE OF UNDESCENDED CAECUM AND APPENDIX.

BY C. A. HAMANN, M. D.

The following case is reported simply to illustrate a point in diagnosis, and as a reminder of the fact that congenital anomalies of the caecum and appendix must be borne in mind in the consideration of obscure intra-abdominal affections.

Mr. S., aged 38 years, referred to me by Dr. S. J. Webster of South Brooklyn, had suffered from pain in the right hypochon-

driac region for five or six years. The pain was almost constant, though worse at intervals, and had disabled him from work for the last few months. There had never been any acute attacks resembling gall stone colic or appendicitis or any other acute abdominal disease, nor was there a history of traumatism. There was localized tenderness, just below the costal border, at the outer edge of the right rectus muscle; the muscle was rigid. No tumor could be felt.

It being impossible from the symptoms present to make a positive diagnosis, an exploratory incision was advised.

Upon opening the abdomen in the semi-lunar line, over the point of tenderness, it was found that the caput coli looked directly upwards, and appendix lay partly under the liver. The caecum was of the "second type" described by Treves, i.e., the appendix arose between two equal sacculi; it had a short mesentery. The appendix was  $4\frac{1}{2}$  inches long and had a mesentery throughout its entire length. About an inch from its base lay a soft faecal concretion, around which there was a shallow ulcer. The coats of the appendix were somewhat thickened, and presented the changes described by Deaver under the head of "chronic interstitial appendicitis." There were no adhesions.

The patient was completely relieved of pain and tenderness and made an uneventful recovery.

Failure of the caecum to descend is not excessively rare. I have seen it three or four times in the foetus at birth, though I have not encountered the condition in adults. Curschmann (*Topographisch-Klinische Studien, Deutsches Archiv f. Klin. Med.* LVIII. Band) describes a number of cases of undescended and misplaced caeca and refers to the practical importance of such anomalies. Struthers (*Edinburgh Med. Journ., Vol. XXXIX., Part I., p. 289*) gives an elaborate account of the "Varieties of the appendix, coecum and ileo-coecal valve."

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ADDRESS DELIVERED AT THE OPENING OF THE  
FORTIETH SESSION OF THE CLEVELAND COL-  
LEGE OF PHYSICIANS AND SURGEONS.

BY CHARLES B. PARKER, M. D., DEAN OF FACULTY.

It is my pleasant duty to welcome you to these opening exercises of the fortieth regular session of this medical school. To you all it is an interesting event. A number of you have just

made the important decision of the choice of a profession and are now entering upon your first year of study and preparation; others are entering upon new and advanced work. The occasion is also one of especial felicitation to the faculty that we can welcome you to the advantages and comforts of this new and commodious building. It is the gift of the friends of Ohio Wesleyan University and the efforts of this faculty for a higher education in medicine. The building is complete in every detail from the ventilating and cold storage plants in the basement to the last detail of the laboratories. Special attention has been given to ventilation and heating and plumbing that the air may always be pure and free from all contaminations.

As in the life of the individual, we have periods of infancy and youth, so the institution has its period of growth. This is the fortieth session. We have passed through a vigorous infancy and a successful youth and are now entering upon the period of complete manhood, fully equipped for the work and prepared to compete successfully with other sister institutions.

As I recall what has been accomplished in the last seven years I am astonished and encouraged for the future. In 1893 this was a summer school without an adequate hospital and with \$7,000 in the bank. In that time we have built a hospital where our students receive exceptional advantages for bedside and clinical instruction, and which is appreciated, as evidenced by our large senior classes. In 1894 the Cleveland General Hospital was built at a cost of \$65,000, and over one hundred thousand more has been paid out for its maintenance during the last five years. And now this building at an expense of \$50,000 for land, building and equipment, a total of \$215,000 at a very conservative estimate, and we may well be congratulated upon the result. It has been possible through the self-sacrificing efforts of the faculty, the President, and Trustees of the University at Delaware and our generous friends here in Cleveland. We are building better than we thought, and none of us here present will ever see this building abandoned for a larger and better. We cannot measure the influence which will go out into our State and Nation with the educated men and women who are to graduate here.

While filled with such thoughts and contemplating our present surroundings, my mind has gone back to the founding and early days of our college, and I wish to beg your indulgence



while I go over in a personal reminiscence the early days, dwelling briefly upon some of those who have helped to give our college its present high standing.

Thirty-seven years ago this college was founded by Dr. G. C. E. Weber. It was at a thrilling period in the nation's history. Our country was in the midst of a civil strife. The North was just learning the art of war, and the glorious victories of Gettysburg, Atlanta and Nashville had not been won. Many young men who had seen service in the army, in the ranks and in the hospital service, were returning home invalided or having served their three years to study medicine.

Dr. Weber, the young surgeon whom Governor Tod had appointed Surgeon-General of the State, was almost unknown outside of his home town, Cleveland. His father was Martin Weber, the distinguished professor of the University of Bonn. Dr. Martin Weber was the first writer upon anatomy who placed the names of the muscles upon them in the illustrations—a method which Professor Gray, of London, adopted but failed to give due credit to its author. Gustav's father intended him for a mercantile career, as he had already two sons in the medical profession, and sent him to America (as offering a better field for a young man), but he became interested in medicine, graduated at the Beaumont Medical College in St. Louis, and settled down to practice in New York City. He immediately met with success, and in 1858 came to Cleveland, on the invitation of the faculty of the Cleveland Medical College, as Professor of Surgery. This college had no hospital advantages. In the examination for appointments for army service this want of practical knowledge was made so apparent to Surgeon General Weber that he determined to found a medical college with hospital advantages. By his efforts subscriptions were secured, Charity Hospital was built **and the Charity Hospital Medical College established in connection with it.** In this work Bishop Rapp, the learned Catholic bishop of Cleveland, took a leading part, and the Sisters of St. Vincent de Paul were established as nurses in charge of the hospital. Thus this school was established upon the principles of clinical teaching, and Dr. Weber became celebrated as a great clinical teacher. For full thirty years he stood weekly in his amphitheater, examining and operating upon a wide range of surgical work, not only general surgery but also special.

In all these years he maintained the highest reputation for accurate diagnosis and conservative treatment; yet he did not

lack daring, and performed the most difficult and unusual operations. I may mention the removal of a large fibroid from the oesophagus, and he performed one of the first successful ovariectomies in this city and continued many years a most successful operator in this line of work.

Distinguished in presence and courtly in manner, he was always the polished gentleman. His presence in the sick room always gave hope and new energy to the patient. Resourceful, he never really gave up a patient but always had helpful suggestions to the end. He was always a student and made pathology his chief study. Though rather slow to adopt new remedies, he always used the standard drugs boldly, and his prescriptions always contained active agents:

But not only was he a master of the surgical craft but he had that rare power of discovering ability in others, and out of the surrounding country called together a remarkable group of men to aid him in his work. Every one of the first faculty became famous in professional work and most of them have ceased from their labors.

On the roster of the first faculty were the following names:

Gustav C. E. Weber, Prof. Civil and Military Surgery and Dean.

Leander Firestone, Prof. Obstetrics and Diseases of Women.

Addison P. Dutcher, Prof. Principles and Practice of Medicine.

Mark S. Casels, Prof. Legal Medicine.

Jacob Dascomb, Prof. Chemistry and Toxicology.

Jacob H. Salisbury, Prof. Physiology, Histology, Anatomy and Secretary.

Robert N. Barr, Prof. Anatomy.

Wm. J. Scott, Prof. Materia Medica, Botany and Pharmacy.

Abraham Metz, Prof. Ophthalmology.

H. B. Payne, President Board of Trustees.

J. W. Russell, President Board of Councillors.

O. D. Palmer, President Board of Censors.

Foremost among them was Leander Firestone, of Wooster, O., a giant in stature with a peculiarly powerful and sonorous voice. He lectured upon Obstetrics and Diseases of Women. I remember well his lectures upon the latter subject. In his opening address he dwelt most eloquently upon the direful effects of feminine style of dressing, but always closed a beautiful perora-

tion with the sentiment that with all their follies in dress, and whatever the style, and in all styles, we loved them still.

Addison P. Dutcher was Professor of Medicine. There may have been more profound scholars than Professor Dutcher, but no man ever prescribed the materia medica any better than he did. To-day his time-honored recipes are found in many of the older drug stores of the city. He was a hobbyist and he rode them to the limit, but he was a good teacher.

Jacob Dascomb was Professor of Chemistry. Those who had the pleasure of knowing this rare and amiable man can never forget him. He loved his students as he loved his science and dealt gently and justly with each. We remember him in his later years, infirm but inspired with a zeal for work and experimentation. How carefully he prepared the experiment, always suggesting that it might be a failure but it never was! So thorough and painstaking was he.

Abraham Metz already enjoyed an enviable reputation as a general and special surgeon when he became a member of the faculty. He was a beautiful operator in eye surgery; so calm, so swift and so sure, and his German habit of exhaustive study and research made him one of the most thorough teachers in the faculty. His death in 1876 was a great loss to the college.

Jacob H. Salisbury had already begun his investigations into minute parasitic life when he was made Professor of Physiology. In 1863 there were not many medical microscopists and Dr. Salisbury's microscopic examinations of the blood in malaria attracted much attention and criticism to himself and he finally resigned from the faculty. He was an able man, an original investigator and is to-day one of the most celebrated diet specialists, as well as richest practicing physicians in New York.

Dr. William J. Scott had been a successful practitioner in an obscure town in central Ohio when Dr. Weber invited him to come to Cleveland and take the chair of Materia Medica, and in a short time that of Practice of Medicine. We have often heard him tell of those early days, and how he was compelled to rely upon his own originality on many trying occasions. While other professors were admired and some feared, Dr. Scott was loved. He was "Pap Scott" to everybody in the class. He was a natural and original teacher. How well I remember his advent into the lecture-room, with his old frayed note-book, his efforts to find his place amid its loose leaves while the applause of the students was subsiding, and then with a smile all his own he would close the



book, or if he left it open, never refer to it again, and go on and give a practical, personal account of the subject in hand. He became eloquent when he came to his favorite themes, e. g., compensatory hypertrophy and dilatation of the heart. No vivisectionist could make the heart's beats more distinct. We saw the right heart muscle growing thicker and thicker, and then thinning and the blood column damming back. We saw the heart as if it were beating bare before us, and we never forgot it.

It was such rare spirits—men of such attainments—that Professor Weber gathered around him. Is it any wonder that the success of the school was instantaneous and complete? At the very first session there were 68, and the hundred mark was passed the second year, and later the average attendance was from 125 to 140.

When I entered the school in 1874 the name had already been changed from the Charity Hospital Medical College to the Medical Department of Wooster University, and had removed from the old Hoffman Block, corner of Superior and the Square, where the Cuyahoga Building now stands, to the building we have just vacated across the way. Here, in addition to most of those I have mentioned as early professors, were Dr. A. C. Miller, Teacher of Genito-Urinary and Venereal Diseases. Alas! that I have no notes of his opening lecture! It would be a curiosity of literature, but he never repeated it after 1874! He was an excellent teacher, exact, methodical and persevering. The continuance and success of the school after 1881 was largely due to those qualities and to his ceaseless labors for its success.

Traditions of Professor Kitchen as a Teacher of Anatomy still linger among our students. In his day he had no equal as a teacher in this department, and his ability to get work out of the students. His personality and his way of pointing his finger at a man were so disturbing that upon one occasion a student replied that he did know—but the Doctor had hypnotized him!

Dr. H. J. Herrick, Professor of the Principles of Surgery and Surgical Pathology, took his first lessons in surgery upon the battle-field, as he entered the army as Assistant Surgeon soon after graduation. He served with distinction and on his return entered the medical school. Dr. Herrick is a very positive man in his knowledge and therefore a very good instructor. He introduced us to that great master of surgical pathology, Sir James Paget, who was his patron saint and at whose shrine we also worshipped.

Dr. Frank J. Weed was a favorite pupil of Dr. Weber and very closely associated with the Doctor. It was a principle with Dr. Weber to appoint graduates of the college as far as possible to responsible positions in the faculty as they became vacant. Thus Drs. Kitchen, T. Clarke Miller, Dalby Lowman and myself had been made teachers and ultimately professors. Dr. Weed, with his very extensive practice, did not feel able to accept any of the numerous positions offered him during Dr. Weber's deanship. When the college was reorganized he took an active part, accepting the chair of Clinical Surgery and ably filling it and the office of Dean until his untimely death. He labored incessantly for the success of the college and was able to inspire others with his enthusiasm and love of work.

I cannot close this *resume* of those who devoted their lives and abilities to the welfare of the students of this university without at least mentioning the name of one, who, though he served in a minor capacity as Professor of Microscopy during the summer course, was yet an original investigator and inventor and has left his name forever in high regard among all workers with the microscope, William B. Bezner. Had he had the opportunities of early education, he would have become distinguished in a broader field. There was nothing too intricate for his ingenious and inventive mind to compass and understand; he could make anything from an engine to a mechanical finger for picking up microscopic objects and laying them in any position desired. He invented a bridge which has been adopted by a large bridge building company, and he cut lines upon glass slides off-hand which were as true and exact as those made with the finest machinery.

And so, while the attendants have been carrying supplies and apparatus from the old building into the new, in my imagination I have seen these and other distinguished teachers and instructors, many of them no longer in active practice, some forever at rest from their labors, come and go as of old, and with them the numerous classes of students thronging in and out of the doors of the old college which we have now left forever. We may despise the dingy old building with its inconveniences and disagreeable odors and at the same time for those of us who were students there, it holds countless memories of a happy past.

It is interesting to note for a moment the history of the ground upon which this building stands. Here, over fifty years ago, a body of men professing *one* faith and believing that in fact all men are born equal, and refusing to worship longer with those

who countenanced slavery, built a church and worshipped until the cause of liberty was triumphant. This is consecrated ground. This church was a haven of refuge for many a runaway slave and a regular station on the underground railway to Canada in the ante-bellum days.

It is rather singular that this college, which was founded amid the clash of arms, is finally planted upon this spot consecrated to that principle of human liberty which was the fruitage of that great civil struggle.

We enter this grand structure, the gift of the friends of this university in Cleveland to the medical profession. We can look forward to a time when this building, too, will be old, when it, too, will have gathered to itself memories, when those who to-day go in and out will have ceased from all work. May these memories be as sweet, may the work done be as honest, may the professional knowledge and character here formed be as sound, and may the same measure of success attend you and those, who, after you, look to this building as their home and Alma Mater, as was vouchsafed to those who graduated at the old college.

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## **Abstracts and Extracts.**

WM. CLARK, M. D.

### **"ALCOHOL FOR SOLDIERS."**

In spite of the fact that alcohol in large amounts is a dangerous stimulant and a slow poison, it can not be successfully denied that in small amounts it is a food, for it has somewhat of the chemical composition of starches, sugars and fats and burns up in the body, producing heat and other forms of energy. The amount that can be oxydized in one day is very small, a mere ounce or two, and as an equivalent energy may be obtained from a generous slice of bread and butter, we are justified in ignoring it as a food under ordinary circumstances. The war now being waged over the theory as to whether or not it is food, is a tempest in a teapot, of no practical utility. Man, like all other animals, must adhere to the foods by means of which he attained his present zoological position. He was an intelligent, active and powerful being long ages before he knew of alcohol and it is more logical to suppose that he can safely change to alcohol than to suppose that we can feed meats to horse.

Discussions of alcohol are thus narrowed down to its use as a stimulant. Wherever man goes he finds a stimulant necessary



if he is to live long and work well, and the stimulant which has survived the test of many centuries is caffeine. Some use it in coffee, others in tea or cocoa, and its use is almost universal in civilization. Even among the most rabid antagonists of all stimulants, its use may be so excessive as to be harmful. Its moderate use seems to fill all the needs of existence of normal men in normal surroundings and makes any other stimulant unnecessary.

We are thus still further limited in our discussion to the use of alcohol as a stimulant for abnormal surroundings. For one class of abnormal men, the diseased, its use is such a fixture of the soundest medical practice that it is a waste of time to discuss it. It is a medicine classed with strychnine, digitalis and all other stimulants, and in the hands of intelligent physicians saves so many lives that we cannot dispense with it. The very small number of physicians who are opposed to its use are so illogical in their argument that we can safely ignore them. When life flags and needs a whip and a push, we do exactly what an engineer does when he wants his engine to put forth an extra exertion. He uses an easily burned fuel. Alcohol likewise furnishes energy for the human machine just when it is most needed, for it is more easily oxydized than any other food, and it is the whip at the same time. No other stimulant can take its place.

Another class of men who need alcohol consist of those who, though not abnormal, have passed their prime and are on the downward path to the grave. There does not seem to be any reasonable doubt that they are better off, work better and live longer if they help the machine along a little. A toddy in the afternoon helps to repair the damage of day's work, aids digestion and other vital processes and certainly preserves good men for many years of useful work. We all know old men who would do better if they were not so constantly feeble and exhausted from depending on their own failing powers.

The next class consists of abnormal frail men who in former ages invariably perished before maturity. Modern science and civilization save them as babies, develop them as adolescents and keep them alive as adults. Without help they are a prey to all disease-producing bacteria and other enemies. They fill our clinics, hospitals, asylums, almshouses and jails. Whether they ought to be helped to survive and keep the race deteriorated is a foolish discussion, for such family lines die out as a rule and the species purifies itself. Yet in the number are men of extreme value to the nation and to the world, men, for instance, with big brains but a

tendency to consumption, who could be preserved by a little alcohol judiciously administered. Men once lived in the open air and that is still their normal existence, for housing is fatal. City life is particularly deadly, and cities are called "consumers of population," which comes in streams from the country. This unnatural, unwholesome existence is so bad and vitality is so reduced that artificial food and stimulants are needed in more cases and much sooner than in the country. The liquor traffic is a necessity of modern deadly city life.

Now soldiers do not belong to any of the above classes, for they are absolutely healthy, normal young men, so carefully selected that three-fourths of the applicants are rejected. At home they lead a healthy out-door country life. Under normal peace conditions, alcohol is no more necessary for them than it is for horses. Once upon a time the soldier was given whisky every day, but that was a time every gentleman was expected to get drunk daily before bedtime. Nothing can be more certain than that the daily issue of whisky to young men who did not need it, led to drunkenness and ruined many a promising life. The practice was so vicious that when the whisky ration was abolished and more food issued in lieu of it, a grand thing was done for the army.

The usefulness of alcohol for soldiers is then restricted to such times as they need it as a result of abnormal conditions. The chief occasion is when exhausted from overwork and insufficient food in the field. Though the commissary department furnishes every conceivable practicable article of food which human ingenuity can suggest, it is not possible for them to supply everything which a man should have to keep him in health, and the law will not permit them to supply enough of the articles composing the ration. The law does not give the soldier enough to eat, our ration being one of the least liberal in the world. In garrison we have means of getting additional supplies which the government is too niggardly to pay for. In the field these means fail and if the soldier cannot buy extras he is hungry, underfed and exhausted and instinctively turns to alcohol for support. If the exhaustion continues he acquires a chronic alcoholic craving and sinks into drunkenness just as civilians do, for this condition, whether steady or periodical, is a symptom of exhaustion in nervous, unstable men, the congenitally weak being the chief sufferers. In soldiers it is a result of exhausting work in the line of duty. Charitable forbearance to drunken veterans, ruined by their sacrifices for the civilians who stayed at home, is a Christian virtue not expected of

the Pharisees. The tremendous consumption of alcohol in our civil war and the huge crop of drunken veterans, many of whom subsequently recovered under home feeling, were directly traceable to the exhaustion of overwork and starvation. Every civilized nation in the world except ourselves combats this field exhaustion by issuing spirits at the proper times. They prevent drunkenness, but we prefer to "reform" the drunkards after the damage is done.

The temperance agitation which has been of such inestimable benefit in checking that frightful drinking habit of the last century, has been so strong in America as to swing the pendulum of public opinion too far. In abolishing the worse than useless daily grog it has also deprived the soldier of a much needed support in the field. There can be no question that whisky should be restored to the commissary stores for use in conditions of exhaustion. The surgeon is the only man in the army who can give government liquor to exhausted men, and there is no reason for changing this custom, but I do think it very illogical to tell the surgeon: "You may stimulate men in hospital exhausted by the typhoid bacillus, but you must not stimulate those out of hospital exhausted by fatigue and starvation."

The last abnormal condition affecting the soldier is the heat of the tropics. It causes increased tissue change in the same manner as the hot baths of Arkansas, to which we send cases whose body chemistry is too sluggish and needs stimulants. The first effect of the tropics then is increased mental activity and feeling of well being, so that new-comers are generally delighted with the climate, write home enthusiastic letters and even cable that the climate is perfect. In accordance with law this excessive activity results in exhaustion, which shows itself in every conceivable way, muscular, nervous and mental exhaustion, lowering of all the vital processes, rapid aging of men past their prime, feeble resistance to disease and slow recoveries. The only logical conclusion is to treat such cases exactly as we do at home. Once upon a time doctors starved their exhausted patients, but they killed so many that a great genius who started the reform was so proud of his discovery that he asked that these words be engraved on his tomb: "He fed fevers." Nowadays we resort to the same treatment for every exhaustion, no matter where we find it, in the hospital, asylum, sanitarium, or in the tropics—feeding.

But food is not enough. We must stimulate them or the nourishment is too much for the feeble digestion, and the alcohol supplies energy just when it is needed. Hence a whisky ration is



an essential for troops in the tropics, and though I would not issue it indiscriminately, yet it should always be on hand with the bacon and hard tack, ready for use on the recommendation of the regimental surgeon. As a rule the maximum amount should not exceed four ounces a day and some men will need much less and some will not need any.

A naval surgeon has recently advocated a ration of whisky for men after they have had exhausting work in the hot fire rooms of warships. His recommendation is considered safe, for it creates no comment, but this same recommendation as to soldiers exhausted by the constant and therefore more terrible heat of the tropics, has created very unreasonable opposition. Is the exhausted soldier less worthy of being saved from illness than the sailor? Let the mothers answer the fanatics who would prefer the soldiers to come home starved into living skeletons by our ration in the tropics rather than help them with alcohol. The horrors of Montauk make no impressions on such warped minds. Regiment after regiment arrived at that place, with the men so emaciated and enfeebled by the Army ration in Santiago that they could not walk 100 yards without a halt for rest. Is there a sensible man on earth who would dare refuse stimulants to such enfeebled men?

Alcohol in larger amounts than we have mentioned is a poison except when given in special cases of disease. Its deleterious effects are so well known that it is useless to discuss them here. We need only mention that one of these effects is more exhaustion, and this is the cause of death in many cases of acute alcoholism. Hence there is no reason to doubt that in the tropics this double exhaustion makes excessive drinking more deadly than at home—an apparent contradiction of the statistics which show that the deaths from alcoholism increases as we go north, though the per capita consumption of alcohol is less. In the cool, bracing north few people feel the need of alcohol and only those who are weak from congenital defect or other cause have great desire; and these are the very ones most prone to excesses. As we go south more of the normal people feel the need of stimulation to counteract the effects of the heat, until we reach lands where every one drinks moderately. This has been going on many ages, and some writers believe that the weaklings have been killed off long ago and through the survival of the fittest the sub-tropical civilized races are immune to alcoholism. Whether this is true or not, we must accept the facts that in hot countries all civilized people drink alcohol, though far less of them die than in the cooler regions. Moder-

ate drinking is not only less deadly in the tropics than we were once taught, but it is necessary to combat the exhaustions. These views, which I formulated over a year ago, after a most unwilling acceptance of the facts, I see no reason for changing. As long as we have to keep men in the tropics we might as well face the facts at once.

In a recent editorial, the *Boston Medical and Surgical Journal* shows by statistics, the increased percentage of deaths from alcoholism in troops going to the tropics. If the editor had stopped there he would have been sensible, but he becomes foolish when he states that therefore moderate drinking must also be more deadly than at home and that men should be total abstainers. He only shows the general home ignorance of tropical customs. It would be just as silly to reason that an excessive exercise in the sun is deadly, so also must be moderate exercise in the shade, and, therefore, white men in the tropics had better abstain from all exercise and stay in bed. If a young man stands a tropical climate, he would be foolish to touch alcohol, because it is unnecessary and it may lead to excesses. Yet there is no other proof that its moderate use is a particle more harmful than at home. Its real use is to combat exhaustions and is for those who need it, who I believe are in the majority. We regret to take this view, but it would be dishonest to conceal the facts. In fighting drunkenness truth is the best weapon.

The nervous system of children is unstable and easily poisoned so that stimulants are always harmful, but at what age their use can be safely begun depends upon the race and climate. In southern climes they feed alcohol to children at an age fatal to those of the north, and in the tropics tea and coffee can be used years before it is safe for us. Racial immunities may even reverse rules, for the opium habit so fatal to the nervous system of whites is beneficial to that of the peoples of southeastern Asia. It is probable that for normal men under normal outdoor conditions north of Mason and Dixon's line, teas and coffee had better be withheld until nervous maturity—25 years of age, and alcohol until after full mental maturity—40 years of age. In spite of these theoretical rules, there are no data from which we can prove that the moderate use of coffee as early as 15 or of alcohol at 20, produces an appreciable harm beyond the damage done by occasional excesses so certain to happen to young drinkers. It is more of an ethical than a scientific question.

But boys will be boys in spite of all our efforts to make them act like old men. They think it "smart" to drink occasionally, even to excess, and unless they are guarded they are gathered in by the rum-seller. They fly off the track when they first leave home, as many a college town could testify. In the Army we try to guard our "boys" from harm, always thinking of the dear old anxious "mother" at home. If we could secure a law that no rum shops should exist within ten miles of an army post, we would be very happy. Unfortunately, the rum fiends follow the soldier, camp on his trail, surround every army post, and have a tremendous political influence. To foil them, the "canteen," or "exchange," was started, to see if, by giving the men pleasant reading, amusement and billiard rooms, gymnasias and lunch counters, all on the plan of the Young Men's Christian Association buildings, we could not keep the "boys" from the sharks. To secure those who drank we were compelled to allow beer in a different part of the exchange, separated from the rest. The results—reduction of drunkenness have been superb, beyond our highest expectations.

The "exchange" has become an indispensable instrument for enhancing discipline, and its profits are partly used in feeding the soldier. At this post the soldiers eat one-fifth more than the ration, the excess being thus purchased. The government, instead of being too liberal, is contemptibly mean, as it depends for part of the soldiers' food upon the profits on the sale of beer, profits taken out of the soldiers' pockets. Unfortunately, the rum dealers fight the canteen because it reduces drinking, and the temperance folk fight it because of the way it reduces drunkenness. We perfectly agree with the temperance folk, that as a matter of pure ethics, the soldier should not have beer when he is under normal conditions and given enough to eat, but we believe it is good practice to allow a little and thus substitute a tiny evil for a great one. We have abolished many of the low grogeries around some army posts from which vile drinks formerly ruined young men fresh from home. The greatest opposition to the canteen comes from people who do not know what it is, and many of them are of the same class which condemned Christ for making wine from water and denounced him as a wine bibber.

Statistics can prove anything, and though English life insurance companies show that moderate drinkers live the longest, total abstainers less, heavy drinkers still less and drunkards the shortest, we are justified in slightly modifying this order. The class of



total abstainers contains many unstable short-lived men who cannot stand any alcohol and who abstain from self-preservation. Young moderate drinkers surely injure themselves by occasional lapses. We are then safe in classifying young, vigorous civilians as to their vital powers in the following order: Abstainers, Moderate drinkers and heavy drinkers. We should expect that when we take these three classes to the tropics the first would stand the climate the best, the second less and the third, being the most damaged before hand, furnish the most cases of collapse. This is said to be a fact, but that does not alter the other fact that they all need a little alcohol when they are exhausted. Men accustomed to alcohol are even said to fare badly in the tropics if they abstain and thus upset a habit, bad though it be.

We are safe in predicting that as the men, on coming home, find the cool air indescribably refreshing and stimulating, they will not crave alcohol as they did in the tropics, and we will not have nearly the large percentage of drunkards that were among the veterans of the civil war.

In the tropics a long time ago people were advised not to look upon wine when it is red, and were told that no drunkard could enter the Kingdom of Heaven. The apostle Paul, from his experience in the tropics, wrote this advice to Timothy: "Drink no longer water, but use a little wine for thy stomach's sake and thine often infirmities." Thus, correct ideas upon the use and misuse of alcohol are probably as old as the knowledge of alcohol. Recent scientific knowledge has added little or nothing to the practical rules in use for two thousand years.

CAPT. CHAS. B. WOODRUFF,

Assistant Surgeon, U. S. Army, Fort Riley, Kansas.

*In Army and Navy Register.*

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The surgeon who believes he can at the time he first sees a case of appendicitis make a differential diagnosis of the pathologic conditions that are present, and predict those which are going to occur, is mistaken. The surgeon, who, at the end of twenty-four hours, says that he can predict the course a case is going to take, from the appearance of the patient and the general symptoms manifested, is mistaken. The same holds true of forty-eight hours and of seventy-two hours. After a certain number of days we can with tolerable certainty predict the outcome of the case. I believe with most surgeons that we are un-

able to state in the first twenty-four hours what the course of a case is going to be. I believe every honest man admits that the mortality of appendicitis is greater than two per cent. I believe that every competent surgeon thinks that he can operate on a case of appendicitis, when the disease is still confined to the wall of the appendix, with a mortality of two per cent. or less. Therefore, my conclusion is that we are not justified in holding a single case of appendicitis beyond the first twenty-four hours after the diagnosis is made, and it is my belief that, in an enormous percentage of the cases, the diagnosis can be made as absolutely in the first twenty-four hours as it can at any other time.—*J. B. Murphy in International Journal of Surgery.*

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But it is really a matter of even more importance to mankind at large, for it would indeed be a sorry outcome of all the increase of knowledge which has been gained by so much labor, if instead of leading to greater perfection of surgical work among the mass of the profession, it were merely to lead to the concentration of surgical practice upon that small number within the profession who are able to obtain hospital appointments. Yet such has been the tendency. To many an aspiring surgeon a visit to a thoroughly up-to-date operating theatre is a depressing experience, for he feels, and sometimes he is even made to feel, that to attempt to enter upon the higher walks of surgery without the aid of such helps and appliances as he finds there on every side, almost an impertinence. And there is something to be said for such a view. The surgery of to-day does not concern itself merely with doing operations which are urgently necessary, and without the doing of which the patients would quickly die. Modern surgery is to a large extent a surgery of election. Operations are done not merely because they are necessary, but because they are considered safe; this safety hinges almost absolutely upon the maintenance of asepsis; and if it is true that such a degree of asepsis as is essential for the safe performance of operative work can only be secured by the elaborate and costly surroundings provided in modern hospitals, then good-bye to surgery for the ordinary practitioner, and good-bye to the benefits of surgery for that large portion of mankind which dwells outside the reach of hospital treatment. Yet the tendency to restrict operative work to hospital surgeons is one which is strongly supported not only by the public, which always votes for specialism, but even among our profession. It is only quite recently that it was urged by a

well-known American surgeon that "modern surgery is best done in hospitals, which can afford every facility for clinical investigation," the view taken being that the constant bacteriological testing of surgical technique, which is only possible where there is a perfectly equipped clinical laboratory, "is the first requisite for work of high standard."

Although this is in a sense true, and although it is to be admitted that operative surgery of the highest type is most easily performed where every possible appliance is at hand, the teaching that the practice of surgery should be more and more confined to those who have these advantages, and that the rest of the profession should accept a humbler role, and should, in commercial phraseology, become the country agents of great operating firms, is one that we should very sorrowfully and reluctantly accept; and all the more so since recent surgical developments have shown that what may be called emergency surgery demands surgical skill of the highest type. If it were true that emergency surgery need only be a sort of "first aid" it might be reasonable to argue that the greatest good to the greatest number would be attained by ordinary surgeons restricting their ambitions to simple proceedings, and sending straight to hospital every complicated case. But this is no longer the position of affairs. Nothing is more clear than that if the best is to be done in purely emergency work the surgeon must be possessed of a high degree of surgical skill, and must be able to carry out his proceedings without delay and with the same degree of asepsis as is found necessary for the highest class of work done in hospitals. A man gored by a bull, a "run-over" case with perhaps a rupture of the liver, a woman with a perforated ulcer of the stomach—all of them emergencies which may occur in the remotest country village—require for their proper treatment the highest type of operative surgery, and men able to tackle such emergencies properly need not stand aside from any surgery that is likely to come in their way.

Those then who despair of surgery outside hospitals are placed in a serious dilemma. Either emergencies must be bungled or surgery must be rendered possible even without the gorgeous appliances which we see in hospitals.—*From The Hospital.*

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"THE ONE SIDE."

It is against all reason to suppose that a surgical patient can receive the proper amount of skill and attention at the hands of a



general practitioner that he deserves. It is really criminal that a man totally unfit to do surgical work should dare to do it. In his heart he should know that he has not that proper amount of skill at his command that is due his patient, and he should refuse to perform major surgical operations when he is given the opportunity. It is an injustice to the patient, to the surgeon, and to the physician himself. Why, then, are we to be victimized by these self-styled surgeons? It is high time that the profession should take cognizance of this abuse and rectify it. The surgeon is a specialist as much as the ophthalmologist, the aurist or the gynecologist. He should be regarded in that light. Would a general practitioner dare to take eye cases? No. And why not? Simply because he has been taught to appreciate his inability to work along these lines, and so he sends his eye cases directly to the ophthalmologist. It is because of his lack of appreciation of surgery as a specialty that he has the supreme conceit to handle surgical cases as they come to him. We say that it is not right, and that it should be stopped.

The other side of the picture also deserves attention. Granting that surgery is a specialty, why should the surgeon handle medical cases? He should not. It is unjust to the medical practitioners that the surgeons to whom they send their surgical patients should attend medical cases which they are called to see. The surgeon should practice reciprocity. He should turn over his medical work to the practitioner, for the same reason that the practitioner should turn over his surgical work to *him*. In that way the community will receive the best possible attention at the hands of the medical profession.

The surgeon is a specialist, and the medical man is a specialist. If this is borne in mind conscientiously, the matter will adjust itself.—*Interstate Medical Journal*, May.

“THE OTHER SIDE.”

Why is it impossible for a man to say he is a general practitioner including surgical work? How does it lessen a man's mechanical skill because he is acquainted by both study and treatment with the general diseases causative and relative to the application of that skill? Why is he less competent to remove enlarged cervical glands in tuberculosis because he studies and treats the glandular enlargements of other diseases? Who taught us the vital processes in connection with bacterial invasion of the appendix? It was the pathologist and physician, and after that the surgeon's definite, accurate, mathematical principles were easy

of application. General practice, including surgical work, is the natural and ideal medical life, for reverse the picture and you will find no special surgeon who is not from the forced necessity of his work bound to study general medicine. Then why does it lessen the mechanical skill of his hand to engage in its practice? So I maintain that a general practitioner, including surgical work, is neither anomalous nor necessarily incompetent, but the natural result of modern scientific medical study. It does not appear to have been demonstrated that only the one who limits his work should be allowed to do such work, or the work that he does best be not attempted by another, because it may not be so well done.

It is a fact well known that the day when a man may claim to be a specialist in every department of medicine is long past, but it remains to be proven that the study and treatment of diseased processes prevents or in any way hinders a man from acquiring the mechanical principles and technique necessary to do good, if not the very best, surgical work.

Many of the technical principles of operative technique are pure tricks, as everybody knows, and as simple as standing an egg on end after some wise Columbus shows you how. Then it seems to me wholly unfair to assume the exclusive right to do a certain work because one may do it the best, and wholly unjust to question a man's motives because he attempts it. It is a well known fact that "there's as much human nature in some folks as there is in others, if not more," as Mr. Harum says, and way down in my heart I may have my own opinion of the intellectual development of the individual who passes me by and consults the doctor next door. But who gave me the right to question that other doctor's motives because he does not at once refer the case to me? If such dictum prevails, then what becomes of our teaching, our clinics, our operating amphitheatres, and our books with their careful and trustworthy delineation by cut, diagram and text of how to do it? If a man's motives are to be questioned for trying to do, what is to be said of the motives of the one who takes his money for pretending to teach him how to do? If the master honestly taught him, then he is competent, for the master says so on sheepskin under seal and signature, and his motives are not to be questioned. If the master only expects or wishes him to become an advertiser of the master's work or a feeder of the master's consultation room, then are the master's morals doubtful and his motives most decidedly not altruistic.—*Indiana Medical Journal*, May.

Dr. Franklin Martin, of Chicago, has been working for some time past devising a safe method of ureteral implantation into the rectum, with the idea of the removal of the bladder in those cases of carcinoma involving the bladder and uterus.

After a good deal of experimentation and work upon dogs he arrives at the following conclusions:

1. Removal of the bladder as a preliminary to or accompaniment of hysterectomy for cancer in order to extend the possibilities of surgery for malignant disease of the pelvis is a justifiable operation under certain desperate circumstances, and the recorded cases in the literature of uretero-rectal and vesico-rectal surgery encourages me to predict that the operation may become something better than a desperate alternative.

2. In the removal of the bladder the ureters should be transplanted into the rectum or sigmoid flexure in order to (a) provide reservoir room or a substitute for the bladder, (b) in order to obtain continence, (c) in order to obtain emptying power under the control of the muscles of the individual.

3. The principal objection to making the lower bowel a substitute for the bladder is the supposition that nephritis, as the result of ascending ureteritis, will invariably occur as the result of uretero-intestinal anastomosis and early death will be the inevitable outcome of the procedure. This supposition is supported by (a) theoretical grounds based upon the assumption of the inherent inability of the ureters to resist the septic bacteria always found in the intestines; (b) on the result of innumerable experiments upon animals which records show almost without exception destructive infection of the kidneys; (c) the death of three cases from nephritis and pyonephritis in the forty-eight cases on record which convalesced from the primary operation.

4. The negative to the supposition that destructive nephritis will invariably occur as the result of uretero-intestinal or vesico-intestinal anastomosis is supported by (a) theoretical grounds, based on the assumption that nothing but actual experience in the human individual can prove that the ureters and kidneys may not immediately resist or rapidly acquire an immunity to infectious material found in the intestines if they are artificially deflected into these organs; (b) the record of forty-eight human patients with vesico- and uretero-rectal transplantation living and a large percentage still well at periods varying from a few months to twenty-four and a half years; (c) the record of human patients



with skin implantation of the ureters living at varying periods from one to eighteen years.

5. By the removal of the bladder and the transplantation of the ureters into the bowel the amount of pelvic tissue which can be safely removed is materially increased compared with ordinary hysterectomy, it being possible to remove the broad ligaments to the verge of the pelvis, thus gaining fully an inch laterally, and the removal of the bladder, the lower end of the ureters and the urethra when necessary, materially enlarging the field of operation anteriorly.

6. *The operation of extirpation of the ureters and bladder* should not be undertaken by one not thoroughly experienced in pelvic and abdominal surgery and by one who has not thoroughly familiarized himself with the details of uretero-intestinal anastomosis by a thorough preliminary apprenticeship in experimental operations on animals.

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**Although the Evidence** has been steadily accumulating that the responsibility for the infection of human beings with malaria rests upon the mosquito, further tests of this theory will be awaited with interest. The London School of Tropical Medicine is making arrangements to conduct some final and conclusive experiments in that paradise of malaria and mosquitoes—the Roman Campagna.

Under the direction of Dr. Patrick Manson a bungalow is being erected in the most malarious part of the Campagna; this will be thoroughly guarded and screened by mosquito curtains, and here will reside two skilled observers with their servants. Every precaution will be taken to guard against the possibility of being bitten by a mosquito. It is confidently believed that the entire party will thus escape malarial infection. In addition to this negative testimony, laboratory-bred mosquitoes which are known to be free from malarial infection will be taken to Rome and allowed to suck the blood of patients suffering from a mild tertian form of malaria, and then taken back to London. After a sufficient time has elapsed for the parasite of malaria to develop in their bodies and reach their venom-glands, these mosquitoes will be allowed to bite several healthy individuals who have never been out of England, or had any opportunity of contracting malaria. If the mosquito theory of disease be correct, then most of the persons thus subjected to infection should develop the disease within ten days.—*Med. News.*

# THE Cleveland Medical Gazette

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## Editorial.

"TIS TRUE 'TIS PITY; AND, PITY 'TIS 'TIS TRUE."

The advantages of medical societies to the profession and to each member thereof are great and numerous. To recount them seems unnecessary, because they are familiar theoretically to every doctor in the land. We could cover many pages with arguments showing why, for scientific advancement, for general culture, for social improvement and enjoyment, and for business reasons, the regular organizations of physicians ought to be encouraged, main-

tained, labored for and punctually attended; and every reader would say, "That is true, every word of it, and I heartily endorse it." Professional opinion is about unanimous on that point. And yet, are medical societies encouraged and promoted, maintained, labored for and punctually attended as everybody knows and agrees they should be? Read the following report from the Champaign County Society, for example. Dr. Ludlow says:

"The society remains in the same state in which it has been for the last ten years, one of innocuous desuetude. We meet every month, some months, and usually we have a very large attendance, five or six being present out of a membership of forty. Our society is unusually active, and if it is desired to have a certain member stay away we ask him to read a paper. That settles that fellow and the society knows him no more. The profession in our county is very active, and most of them delight in keeping their lights under brass thimbles and letting a few keep the society just alive. This is a great community to be fed. Any evening gathering is not complete unless the guests are sent home stuffed with indigestion, so it has been suggested that we hold out the inducement of a feed at each meeting and see if that will not fetch them in. If this plan works I shall report to you, and you can recommend it to other county societies, as most of them are in about the same condition."

We recognize the truth of those statements on sight. They look perfectly natural. We have known the like before; more's the pity. And yet, theoretically, everybody believes in medical societies. The few who do not are hopeless agnostics. They are "scallawags," ostracised by the herd, or else voluntary hermits, with private grievances to nurse in secret.

With everybody endorsing medical societies in the abstract; and yet with many societies languishing, clearly something is wrong. There is an incompatibility somehow between precept and practice. Either there is something wrong about the doctors or there is something wrong about the way the societies are conducted. What can the matter be? Will some doctor diagnosticate the difficulty? Perhaps it is not the same in all cases. Can it be possible that in some instances the members have misread or misconstrued the constitution of the society. Perhaps, where it says "the objects of this society shall be to advance medical science, to cultivate friendship and harmony among the members, and to promote the interests of the profession," they have rendered it something like this: "The objects of this society are to advance my per-



sonal ends by making a show of medical science, to afford opportunities to circumvent the other fellow, and to promote the glory and the gain of a few regardless of the rights or the feelings of others or the general good of the profession."

Perhaps in other instances neglect of the medical society is due to indifference, or to sheer laziness of individual members. Perhaps the society has fallen into careless, lifeless ways of carrying on its work and presents no attractions to members, and needs to be shaken out of the rut by the introduction of new features, the presentation of original or up-to-date programs, the infusion of new enthusiasm, the arousing of the professional spirit, and the love for scientific and literary work.

Now that the summer vacations are nearly over and the time approaches for the societies to reconvene, the season is appropriate for taking a fresh start in the life and work of the medical organizations. Let all such societies as have been languishing devote their first meeting, or a special meeting, to a consultation upon the unsatisfactory state of health of the organization and see if they can find out what ails it, and then set themselves to choose and apply the appropriate remedies. If it is found that the society has died since the last meeting and is undoubtedly dead beyond resuscitation, let the former members hold a post-mortem, determine the cause of death and report their findings to other medical societies that are liable to be afflicted with the same ailments. Thus we shall arrive at more exact knowledge of the pathology of medical bodies, and may be able to keep more of them in that state of vigorous and consciously joyous strength and usefulness, which we know they all ought to have. In other words, devote the first meeting or two to the "good and welfare" of the society itself.

S. W. KELLEY.

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JACOB M. DA COSTA, M. D., L. L. D.

In the death of Dr. Da Costa, of Philadelphia, which occurred on September 11th, the profession loses one of its most prominent scientists in the medical world. Cardiac disease was the cause of his death. Dr. Da Costa was born on the island of St. Thomas, West Indies, February 7th, 1833. He was thus in his sixty-eighth year. His early education was received in Germany. His medical training was obtained at Jefferson Medical College, after which he spent two years in the schools and hospitals of Paris and Vienna.

During his active life as a practitioner Dr. Da Costa held various positions as a teacher at Jefferson Medical College. In 1864 he was appointed lecturer on clinical medicine, and in 1872 he was elected to the chair of the theory and practice of medicine. He also held important hospital positions.

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#### PHYSICIAN'S RIGHT TO REFUSE CALLS.

The lay press in Great Britain and in this country has been recently handling the old theme whether a physician has the right to refuse to answer calls. A London coroner's jury, it seems, denounced as inhuman the action of some doctors in refusing to attend a case, and the papers followed its lead. A prominent American journal admits the legal right of the physician to refuse his services, but says that more is expected from him than from the ordinary tradesman, and that we look for some spirit of self-sacrifice from the medical profession. The doctor, according to popular notions, must give his services wherever wanted and at all times, without regard to his own personal comfort or welfare, and his refusal is counted as inhumanity. This is a satisfying sort of self-righteousness, easily assumed, that disposes of other people's rights so freely. A physician has as good a right to refuse to answer a call for his services as has a mechanic or a lawyer, and if he has good reasons, such as fatigue or overwork, no just charge of inhumanity can be made against him. He has also as good a right to refuse to work for nothing as any other man, and it would be better for the profession collectively if he often availed himself of this right. There is no profession that does as much for charity as the medical, and this is true to such an extent that a large section of the public has come to regard what is thus done for them as in the natural order of things and deserving of no acknowledgement. No one wishes to see any moral deterioration or increase of commercialism in the profession, and, indeed, there is no danger of its members as a class repudiating the honorable traditions from the past, but there is no need, on the other hand, that they should acquiesce in the unjust assumptions of pseudo-philanthropic posers, to lay down their rules of conduct and morals for them. That London jury was very probably made up of men who would, in their way of business, do far worse than the doctors whom, in their vicarious conscientiousness, they condemned, without scruple or remorse. As physicians we wish to exercise charity for all, even the offensively self-righteous, but the

common, cheap virtue of this kind in the daily press sometimes makes us tired.—*Journal A. M. A.*

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### THE CLEVELAND COLLEGE OF PHYSICIANS AND SURGEONS.

The fortieth session of the Cleveland College of Physicians and Surgeons was begun on September 19th. There was a large attendance at the opening exercises, which were held in the new college building at the corner of Central avenue and Brownell street. Addresses were delivered by Dr. Charles B. Parker, dean of the faculty; Rev. Dr. Hillman, Mr. W. F. Walworth, and Dr. C. F. Dutton. Dr. Parker's address appears elsewhere in this issue of the GAZETTE.

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### A CLEVELAND PHYSICIAN'S WORK.

The Congress of Anatomists held its sessions at Pavia, Italy, from April 18th to 21st. This place was undoubtedly selected to honor Camill Golgi, whose labors have done so much to clear up the fine structure of the central nervous system. It may be of some interest to the Cleveland medical profession to know that Prof. Kolliker, who, in the absence of Prof. Retzius, presided, reported at some length on the investigations of Dr. C. Sihler.

The report says: "Sihler & Kolliker, On the Nerves of Striped Muscle. This subject was to be discussed in the Italian language, with demonstrations of drawings from Sihler's work, but on account of lack of time the discussion could not take place. But in the transactions the subject will appear in extenso. Here I wish to add only that I am entirely in harmony with the views of Sihler in placing the nerve endings on the outside of the sarcolemma."—Abstract from Prof. Kolliker's resume of the work of the Congress.

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### PRELIMINARY PROGRAM OF THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION, ASHEVILLE, N. C., MEETING, OCTOBER 9, 10 AND 11, 1900.

All members of the medical profession are cordially invited to attend the Scientific Sessions of the Association.

Harold N. Moyer, President.

Henry E Tuley, Secretary.

I. N. Love, St. Louis, Mo., Address in Medicine.



C. A. Wheaton, St. Paul, Minn., Address in Surgery.

L. W. Beardsley, St. Louis, Mo., Canthoplasty in Ophthalmic Practice.

Andrew Timberman, Columbus, O., The Etiologic Relation of Eye-Strain to Epilepsy.

Otto J. Stein, Chicago, Ill., Middle Ear Disease in its Relationship to the Cranial Cavity.

Abstract.—The necessity of recognizing the importance of possible intra-cranial complications in every case of middle ear disease. A discussion of the various avenues of infection, illustrated by drawings and specimens. Symptomatology of intra-cranial phlebitis, thrombosis, and abscess, with report of cases. With stereopticon demonstrations, by J. Holinger, Chicago.

Geo. F. Keiper, LaFayette, Ind., Some Observations Gleaned from Some Recent Cases of Mastoiditis.

Abstract.—Four cases reported; disposal of pus absorbed through mastoid veins by lymphatics; operation upon both mastoids simultaneously for mastoiditis, surgical erysipelas; sclerosing mastoiditis, relief of symptoms by operation; old brain abscess, attack of grippe and mastoiditis, death from pneumonia.

Alex. C. Wiener, Chicago, Ill., Treatment of Tuberculosis of the Spine.

A. J. Ochsner, Chicago, Ill., Relation of Appendicitis to Gall-Stones.

B. Brindley Eads, Chicago, Ill., Ventral Hernia Following Laparotomy.

Abstract.—The importance of this sequel of abdominal operations; the abdominal skin muscles, fascia and nerves; the principles involved in choice of incision; the making and closing of the incision; ventral hernia and its cure.

Geo. W. Crile, Cleveland, O., Technique for Removal of Tumors of the Neck.

Geo. W. Cale, Jr., Springfield, Mo., A Case of Intermittent Hydrops of the Knee.

Abstract.—Patient, lady, age 45. First appearance of trouble five years ago; no history of injury; rapid accumulation of fluid in left knee-joint, which was not painful. Accumulation disappeared in from one to four weeks, with or without treatment. Disease recurred at periods varying from one to six months.

Jas. B. Bullitt, Louisville, Ky., Hernia in Man and Animals.

Thomas H. Manley, New York City, Notes on Fractures Contiguous with or Involving the Articulations of the Larger Bone Shafts.

Abstract.—Fractures involving the joints are always complicated. In Colles or Potts they frequently involve a subluxation. Contiguous with a synarthrodia, they are frequently detected with difficulty. They are often mistaken for sprains.

John L. Jelks, Memphis, Tenn., The Treatment of Peri-Rectal Abscesses.

Abstract.—Peri-rectal abscesses, when properly treated, are not so serious as when poulticing was the practice. Need not necessarily result in fistula. Walls not gotten rid of when simply incised and drained. As soon as fluctuation is obtained, open freely, irrigate through an irrigating curette, thoroughly curetting the abscess wall. Formalin solution used for irrigation; pack with iodoform gauze. Bichloride and carbolic solutions and hydrogen dioxide are objectionable for irrigation purposes. Superficial abscesses should be dealt with in same manner, local anesthesia sufficing for thorough curetting. Formalin in rectal surgery satisfactory.

Discussion.—Thos. Chas. Martin, Cleveland.

Sterling B. Taylor, Columbus, O., Obstipation.

J. Rawson Pennington, Chicago, Ill., Simple Operation for Hemorrhoids; Enucleation.

Abstract.—Hemorrhage controlled by torsion ligature and rubber covered tampon. Less pain and earlier recovery.

A. B. Cook, Nashville, Tenn., Revelations of the Proctoscope in Health and Disease.

Abstract.—Clear and definite knowledge of the anatomy of an organ the first requisite to an intelligent comprehension of its pathology. With respect to the rectum this requisite perfectly met by the proctoscope. Even under general anesthesia the old method of examination left much to the imagination. Proctoscopy substitutes certainty for conjecture in diagnosis and scientific accuracy for guess-work in treatment.

H. O. Walker, Detroit, Mich., Vaginal versus Abdominal Hysterectomy.

Discussion.—C. A. L. Reed, Cincinnati.

R. S. Sutton, Pittsburg, Pa., Cancer of the Uterus and its Treatment.

C. S. Bacon, Chicago, Ill., The Prevention and Management of Infection of the Breast During Lactation.

J. H. Taylor, Indianapolis, Ind., The Girl at Twelve.

Abstract.—The management of girls at the age of puberty; the ill effects of manual labor, overwork in school, emmenagogues

at age of puberty; the many diseases occurring at this time; results occurring from lack of care at this time.

Yeatman Wardlow, Columbus, O., Ectopic Gestation.

Emil Ries, Chicago, Ill., Pathology of Chronic Gonorrhea of the Male Sexual Organs.

Abstract.—Therapy of gonorrhea of internal male sexual organs beyond the urethra as difficult as that of the female sexual tract. Prognosis only apparently better than that of the female. Pathology of internal male sexual organs much more complicated and much less known than that of female sexual tract. Methods of investigation; necessity of large series of cases. Results as to prostate, seminal vesicles, vas deferens, epididymis, testicle. Relations of chronic gonorrhea and disturbed function. Therapeutic outlook.

A. Ravogli, Cincinnati, O., The Gonococci in the Gonorrheal Secretions.

R. A. Bate, Louisville, Ky., Asthma.

Abstract.—Etiology and treatment. "Unquestionably the primary cause of asthma is some constitutional idiosyncrasy" (Loomis.) "Asthma represents one of the effects of uric acid on the circulation." (Haig.) Diet, hygiene, and anti-lithic measures constitute curative treatment.

Discussion.—Thos. Hunt Stucky, Louisville, Ky., C. L. Minor, Asheville, N. C.

T. D. Crothers, Hartford, Conn., The Curability of Inebriety by Medical Treatment.

Abstract.—Inebriety is a neurosis, usually self-limited, and very largely curable. The craze for drink is symptomatic. The real causes are central nerve irritation, exhaustion, poisoning, and starvation. The success of the treatment depends upon accurate knowledge of the causes and conditions present in each case, and the accurate application of general means and measures for their removal. Each case requires special means and measures particularly adapted to meet the conditions present. The family physician as well as the specialist should treat these cases successfully.

Discussion.—T. J. Happel, Trenton.; J. K. Baudry, St. Louis.

Wm. O'Neal Mendenhall, Richmond, Ind., The Determination of Sex.

Abstract.—The determination of sex is controlled by scientific laws, and a family can produce whichever is desired. Many of the



theories which have been advanced upon this subject are unscientific and incorrect.

Frank P. Norbury, Jacksonville, Ill., Pulmonary Tuberculosis in Infancy and Childhood.

W. H. Bates, New York, N. Y., Further Observations on the Clinical Application of the Suprarenal Capsule.

Abstract.—The aqueous extract of the suprarenal capsule is the most powerful astringent, hemostatic, and heart tonic known. It lessens congestion of the eye and other organs. The extract is not irritating or poisonous, and, unlike other powerful drugs, is never contra-indicated. We have no remedy which is so useful in all forms of inflammation.

Albert E. Sterne, Indianapolis, Ind., The Association of Diseases.

Wm. Porter, St. Louis, Mo., The Growing Necessity for Sanatoria for the Tubercular.

Abstract.—The increasing distrust in climate alone. Infection of health resorts; the tubercular a menace to the public; advantages of sanatoria; comparative results.

I. H. Goss, Athens, Ga., Erichsen's Disease: Does it Exist? Various Injuries Due to Accident.

Abstract.—Writer takes issue with Mr. Erichsen in regard to the progressiveness of spinal concussions, and also with cases brought by anti-corporation lawyers, which get well after verdict. Various internal injuries can be diagnosed as readily as external ones with proper care.

Wm. F. Barclay, Pittsburg, Pa., The Philosophy of the Science and Art of Medicine.

Abstract.—Thoughtful minds engaged in ascertaining truth from falsehood. True and false philosophy appropriately applied to results obtained in rational conclusions. Philosophy of Medicine is the comprehension of the truth in the investigation of the science enabling one to arrive at rational conclusions in the study of physical laws which govern organized matter in their normal and pathological condition.

J. E. Allaben, Rockford, Ill., Treatment of Adherent Cysts of the Ovary and Broad Ligament by Incision and Drainage.

Abstract.—Cysts of the ovaries and broad ligaments are one of the most frequent causes for invading the peritoneal cavity. The causes of death after operation in such cases are shock, intestinal obstruction and sepsis. These conditions are invited by the time consumed in releasing adhesions and by raw surfaces result-

ing therefrom. If large adherent cysts were incised and drained, results might be better than is now obtained by removal. The secreting cyst cells are destroyed by the suppurative processes following this treatment, and the cyst wall ultimately removed by absorption. Report of case. The above demonstrated by two celiotomies on the same patient.

L. H. Warner, Brooklyn, N. Y., Differential Leucocytosis.

J. G. Carpenter, Stanford, Ky., Suprapubic Cystotomy for Traumatism, with Median Perineal Drainage.

#### ENTERTAINMENTS.

Tuesday, October 9, 8:30 to 11 p. m.—Smoker at Swannanoa Casino, Buncombe County Medical Society. Smoker, residence Dr. C. L. Minor. Reception, residence Dr. J. A. Burroughs.

Wednesday, October 10, 3 p. m.—Drive on Vanderbilt estate. 9 p. m., Promenade Ball, Battery Park Hotel. 9-11, Reception, New Winyah Sanitarium.

Thursday, October 11.—Banquet, Battery Park Hotel, Buncombe County Medical Society.

Friday, October 12.—Excursion to Round Knob and return, across the Blue Ridge; not longer than four hours. Members to notify Registration Committee at time of registration if they will remain. Lunch served on train to guests of Buncombe County Medical Society.

Headquarters.—Battery Park Hotel, rates \$3.00 per day. American plan. Other Hotels.—Hotel Berkley, \$2.50. Swannanoa, \$2.00 to \$2.50. Oak, \$2.00.

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#### AMERICAN PUBLIC HEALTH ASSOCIATION.

The American Public Health Association, which comprises the United States of America, the Dominion of Canada and the Republic of Mexico, will hold its twenty-eighth annual meeting at Indianapolis, Ind., on the 22d, 23d, 24th, 25th and 26th of October, 1900.

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The regular monthly meetings of the Cuyahoga County Medical Society will be resumed on the 4th of October. This is one of the best county societies in the state, and has accomplished a great deal of good work. The meetings are held on the first Thursday in each month. Let there be a good attendance at each meeting.

The quarterly meeting of the Cleveland Medical Society, to be held 26th October, will be addressed by Dr. L. Emmett Holt, of New York, the well-known author of a text-book on diseases of children. There should be a large attendance to listen to such an authority.

## Periscope.

*Role of Purin Substances in Human Metabolism.* By Richard Burian and Heinrich Schur (*Pflueger's Archiv.*, 1900, 80, 241).—Every healthy adult excretes a certain characteristic amount of alloxuric or purin substances, which is independent of his diet. This is the result of tissue metabolism, and may be termed "endogenous urinary purin." Its amount may be directly estimated by examining the urin after a diet of substances which are practically free from purin compounds (milk, white bread, potatoes, rice, green vegetables, eggs and cheese). Examination of the urin during hunger does not give trustworthy results; but on ordinary diet, the amount of urinary purin is increased by a part of the "nutrition purin," and this may be termed "exogenous urinary purin." The nutrition purin does not pass wholly into the urin; a certain fraction remains in the organism, the purin double ring being broken down. The amount of the remainder (exogenous urinary purin) differs for different forms of food, and is but little effected by the individuality of the subject of the experiment. The following table gives some of the figures quoted:

Diet.	Total percentage of purin sub- stances in diet.	Percentage of exogenous urin- ary purin.
Beef and veal.....	0.06	0.03
Coffee .....	0.2	0.075
Calf's liver .....	0.12	0.06
Calf's spleen .....	0.16	0.08
Calf's thymus .....	0.4	0.1

By subtracting the exogenous from the total urinary purin, the endogenous urinary purin is obtained, and the results agree closely with the numbers obtained by direct estimation; it varies in the majority of people from 0.1 to 0.2 grammes daily; but higher and lower values were obtained.

*Use of Horse-flesh as Food.* By Edward Pflueger (*Pflueger's Archiv.*, 1900, 80, 11).—Horse-flesh by itself causes digestive disturbances, especially diarrhoea. This is partly, but not



wholly, explained by the poorness of the tissue in fat. There is, however, besides, some toxic material in the flesh, which is removed by extraction with hot water or alcohol; it is not soluble in ether. It was not further identified. Horse-flesh, before it is eaten, should, therefore, be extracted with hot water, and mixed with either mutton or beef fat; these solid fats are better than that of the hog. The modern view of fat absorption, namely, that hydrolytic decomposition of the fat is necessary, is supported.

Pflueger's experiments were made on hogs, but recent experiences during the siege of Kimberley have led to the same result. The necessity of mixing the horse-flesh with beef suet was well known to the medical men in South Africa. (Halliburton.)

*Sugar as Food.* By Friedrich Strohmmer (*Bied Centr.*, 1900, 29, 172).—The importance of sugar as food is indicated by the fact that in human milk lactose is the most prominent constituent, and the results of Soxhlet and Biedert's experiments showed that sucrose is at any rate not inferior to lactose.

According to Schumburg, even small quantities of sugar (30 grammes) will renew the power of muscles tired by work, in half or three-quarters of an hour. Sugar is accordingly specially suited for the production of muscular force, this property being increased by the action of sugar on the nervous system in overcoming the feelings of fatigue.

Excessive consumption of sugar is to be avoided, as digestion would be interfered with; no injury to the teeth will result, as is frequently supposed. When properly employed, sugar is of great value as food, especially after bodily exertion.

*Role of Iron in Blood Formation.* By A. Hofmann (*Virchow's Archiv.*, 1900, 160, 235).—Iron in various forms of organic and inorganic combination is absorbed in the duodenum, and is carried in union with proteid in the "transport" cells of the blood to the spleen, liver and especially to the bone marrow. The principal use of the metal is to act as a stimulus to the red marrow. It causes an increase in the growth and activity of the tissue, and so leads to an increased formation of the blood discs. In chlorosis, the bone marrow becomes comparatively inactive.

*Action of Oxygen on the Excised Mammalian Heart.* By Guenther Strecker (*Pflueger's Archiv.*, 1900, 80, 161).—A new apparatus is described and figured for artificially feeding an excised mammalian heart. The most important result of the experiments recorded is the importance of oxygen in the nutritive fluid. Blood containing carbon monoxyhaemoglobin soon brings the

heart to a standstill, not because carbon monoxid is a poison to the organ, for it still remains excitable, but because it contains no free or readily dissociable oxygen. Fresh arterial blood will set such a heart beating again. This need of oxygen for cardiac activity has been previously insisted on by Yeo (*J. Physiol.*, 1885, 6, 535), and more recently in connection with the mammalian heart by Porter (*Amer. J. Physiol.*, 1898, 1, 511).

*Elementary Composition and Heat of Combustion of Human Fat.* By Francis Gano Benedict and Emil Osterberg (*Amer. J. Physiol.*, 1900, 4, 69).—The composition of human fat appears to be remarkably constant; the average of 24 determinations gives H., 11.78, and C., 76.08 per cent. The heat of combustion averages 9.523 cal. per gramme.

*Alimentary Oxaluria.* By Galileo Pierallini (*Virchow's Archiv.*, 1900, 160, 173).—The soluble and insoluble salts of oxalic acid, the latter in smaller degree, are absorbed, and pass as calcium oxalate into the urin. Foods containing excess of oxalates cause the excretion to increase. The absorption of such insoluble oxalates as that of calcium can hardly be explained as the result of the action of the dilute acid of the gastric juice, but is attributed to decomposition, brought about by the presence of alkali carbonates in the intestine.

*Action of Certain Renal Poisons.* By W. Lindemann (*Am. Inst. Pasteur*, 1900, 14, 49).—This records the commencement of a research on poisons which affect the kidneys, and aims at the elucidation of the manner in which the toxins in serum, and in such diseases as scarlet fever, bring about renal disorder. The special poison here investigated is vinylamine, and the experiments were performed on mice, rabbits and dogs, some of which were rapidly killed with fatal doses, and others subjected to chronic poisoning. In immediately fatal doses the main effects in the kidney are explicable by anaemia. In the more chronic cases, the urin is dilute, highly albuminous, and contains casts and epithelial debris; the kidneys show signs of acute nephritis. The intestinal connective tissue is not affected. Certain toxic serums produce somewhat similar results.

*Identity of the Arogenic Bacillus of Milk with the Pneumobacillus of Friedlaender.* By Leon Grimbert and G. Legros (*Compt. rend.*, 1900, 130, 1424).—The arogenic bacillus of milk and the pneumo-bacillus of Friedlaender agree in the following characteristics, and seem to be completely identical: they are im-

mobile, do not liquefy gelatin, and do not produce indolin culture fluids containing peptone, but ferment various carbohydrates, yielding products which vary with the nature of the sugar; and they produce capsules in the blood of animals inoculated with them.

SPENZER.

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## Notes and Comments.

**Dr. Hunter Robb** returned to the city on 20th September.

**Dr. John M. Ingersoll** is to be married to Miss Garvin Oct. 18.

**Dr. Robert A. Smith**, of Ghent, O., was in the city on the 13th.

**Dr. C. W. Smith** spent the month of September in the state of Maine.

**Dr. James A. Ingram**, of 737 Detroit St., died on 25th Sept., after an illness of a few weeks.

**Professor Osler** has, according to the *Polyclinic* for August, become a vice-president of the London Medical Graduates' College.

**Dr. G. R. Feil**, **Dr. Nathan Rosewater** and **Dr. S. L. Bernstein** have removed their offices from 846 Woodland avenue to 1351 Willson avenue.

**Dr. Myron Metzenbaum**, recently on the House Staff at St. Alexis Hospital, is now associated in practice with Dr. A. J. Cook at 2220 Willson avenue.

**Dr. B. O. Coates** has given up his office at 29 Euclid avenue, and will combine his office with residence at — Euclid avenue, the corner of Euclid and East Madison avenues.

**The Cleveland College of Physicians and Surgeons** began its session's work on September 19th. The dedicatory exercises in connection with the new building will be held during the first week of October.

**Dr. Lillian G. Towslee**, on account of pressure of practice, has resigned from the charge of the out-patient clinic in the gynaecological department of the Cleveland General Hospital, with which she has been associated eleven and a half years. Dr. Walter R. Lincoln will take the place thus rendered vacant in the clinic.



**In Neuralgias about the Face or Head**, three minim doses of the tincture of gelsemium every half hour will often act almost miraculously, and leave no ill effects.

**Fluid Extract of Jaborandi** every hour or half hour will produce copious perspiration, without causing any unpleasant effects upon the heart, especially if combined with digitalis.

**The Med. Record** states that morphine is depended upon at the Willard Parker Hospital to maintain the heart's strength in diphtheria. Small doses, hypodermically (grain 1-16 to 1-10), are given. Strychnine, alcohol and nitroglycerin are also employed.

**Goiter.** Dr. Dock says: "In my experience the removal of a patient with a growing or intractable goiter to a part of the country where the disease is less common has been followed by complete disappearance of the tumor, and some of my correspondents have had similar experience."

**Society for Psychial Reseach Founded in Colorado.** A society for psychical research has been founded at Denver. The objects of the society as outlined in the constitution embrace, first, study of the possible reformation of criminals along the line of psychology, instead of the present system of penal servitude; second, applied psychology in extending the scope of influence in the treatment of chronic diseases, commonly looked upon as incurable; third, general investigation into all occult phenomena, embracing trance, catalepsy, somnambulism, hibernation, telepathy, clairvoyance and spiritualism.

**The faculty of the Cleveland College of Physicians and Surgeons** has made the following promotions and additions in its teaching staff: Dr. W. A. Tims, professor of anatomy; Dr. W. H. Merriam, associate professor and demonstrator of anatomy; Drs. T. Morris D. Stepp, W. E. Lower and Frederick C. Taylor, instructors in surgery; Dr. Charles G. Foote, assistant in surgery; Drs. Martin Friedrich and I. Friedman, lecturers on medicine; Dr. Harrison G. Wagner, instructor in physical diagnosis; Drs. Alfred S. Maschke and George Seeley Smith, assistants in medicine; Drs. A. F. Spurney and Lillian G. Towslee, instructors in diseases of women; Dr. Walter R. Lincoln, lecturer on diseases of women; Dr. Gustave R. Feil, assistant in gynaecology; Dr. John N. Lenker, assistant in diseases of ear, nose and throat; Dr. Arthur E. Chatfield, assistant in dermatology and venereal diseases.

**Michigan Physicians "Strike."** According to press dispatches the physicians of Ludington, Mich., have entered into an agreement that no one will accept a smaller salary than \$600 per annum to act as health officer. The common council of the town have fixed the salary at \$300 a year, and as a consequence the town is without any health officer.

**The Hospital Pasteur,** founded by a lady for the application of Pasteur methods, and situated in the Rue Dutot opposite the Pasteur Institute, Paris, was opened on July 1. The director, Dr. Louis Martin, who lives in the hospital, is responsible solely to the Committee of the Pasteur Institute, to whom at each annual meeting he will present a report. The Pasteur Hospital contains fifty-eight beds, distributed in two pavilions. For the present it will be reserved for the treatment of diphtheria and hydrophobia. No charge is to be made for treatment.

**Consanguineous Marriages and Consumption.** Dr. C. A. Davies of the Isle of Man in a recent communication to the British Medical Association said: Consanguinity in marriage among the Manx people had led to much illness in the off-spring. There has been little crossing of races among them since the twelfth century, and a custom exists on the island to-day of discouraging marriages between persons living in different parishes. Hence there exists all over the island a condition of close "inbreeding." As a consequence the general death-rate from consumption is 25.70 per 10,000, double that of England and Wales. In Lonan, an isolated part, where all of the inhabitants of the parish have only three or four surnames, the rate is 41.79 per 10,000, while in Peel, where many more strangers come, it is only 15.19.

**Surgical Operations in Hospitals for the Insane.** Dr. William Mabon (*Albany Medical Annals*, August, 1900) says: This paper does not profess to present new theories regarding the treatment of insanity, but calls attention to the abundant opportunities for surgical work afforded by our hospitals for the insane in cases in which it will promote the comfort and well being of the patients. The author does not refer specially to brain surgery, in which the field is limited; but rather to any surgical intervention which may add to the comfort of insane patients whether it holds out much hope for their mental relief or not. Several cases are recorded in some of which, operations performed on purely general principles had a direct and unexpected result on the brain condition.

**Technics of Vaccination.** Dr. P. Weissgerber advises the use of a knife for vaccinating and urges the strictest asepsis to insure absence of infection of the wound. He particularly emphasizes the fact that severe squeezing of the skin is apt to foster infection, if there are germs present.

**Carbolic Acid and Mastoiditis.** W. C. Phillips (*Med. Rec.* August 25, 1900) says that pure carbolic acid is without peer in the treatment of suppurative conditions about the ear and its accessory channels. It may be applied with a cotton swab or by an atomizer, allowed to remain *in situ* thirty to sixty seconds and neutralized by alcohol. Under its use unhealthy granulations become normal, discharge ceases and often secondary operations are avoided.

**The Anti-arsenic Law in Massachusetts.** The new anti-arsenic law which goes into effect in Massachusetts on January 1, 1901, is arousing much criticism among the Massachusetts manufacturers, many of whom claim that the statute is nonsensical and uncalled for. The law imposes heavy penalties for the sale or possession of fabrics or paper containing more than 1-100th grain of arsenic to the square yard of dress goods or 1-10th grain of any other article.

**Living Child Delivered by Forceps After Death of Mother.** Fleischmann (*American Journal of Obstetrics*) reports an interesting example of these exceedingly rare cases. The author was summoned to a primipara 30 years old, in labor about thirty-six hours. Membranes ruptured twenty-four hours. Edema of the lower extremities. Pulse and respiration normal. Fetus in L. O. A. position, its heart sounds regular, head in pelvic inlet. Os admits two fingers. During pregnancy the patient had suffered from palpitation and dyspnea. She had taken digitalis amylnitrite. Because of the rapidly recurring pains auscultation and percussation of the heart was impossible. To overcome the rigidity of the os hourly hot vaginal douches were ordered. When seen again, four hours later, the patient's condition had changed for the worse. The pulse was irregular and could not be counted. There were dyspnoea and cyanosis. The os was fully dilated. While preparations were being made for immediate forceps delivery, pulse and respiration ceased. Artificial respirations and injections of camphor failed to revive. The forceps were applied ten minutes after death; a slightly asphyxiated child was delivered, which was quickly revived and continued to live.



**Some of the London Doctors** are going in strongly for a new and fashionable cure for their adult patients who suffer from indigestion, etc. They prescribe a quarter of an hour's vigorous exercise in the morning with skipping ropes.—*Med. Age*.

**The Treatment of Hay Fever by Suprarenal Gland.** Dr. B. Douglas commends both the local and internal use of this remedy. A six per cent. solution may be sprayed into the nose every two hours until the symptoms are controlled. Internally, five grains of the saccharated extract are given every two hours until some giddiness or palpitation is observed, or until the vasomotor paralysis in the nose is brought under control. Then the dose should be diminished, though the remedy should be continued until the hay fever season is safely passed. Dr. Douglas regards the remedy as almost a specific for this disease.

**Ice in Seasickness.** Among the innumerable remedies, do not forget a Chapman's ice bag, applied to the nape of the neck during the continuance of the attack.

An ordinary rubber bag will answer. The beneficial effects obtained from the use of ice applied to the spine in spinal irritation, and to other portions of the body in irritable conditions of the circulation, and especially of the nervous system, has suggested recently its use in seasickness.

The pathological condition developed in this most uncomfortable sickness it has been found in many cases has been promptly relieved.—*N. Y. Med. Times*.

**Decreasing Birth-Rate in Europe.** New statistics demonstrate the fact that in all the countries of Europe, with the exception of Russia, the percentage of increase by births has been diminishing since 1891, the average decline being three per cent. The greatest difference is shown by England, where births have receded from 34 per cent. to 29.1 per cent., and the smallest by Norway, namely, 0.1 per cent. From 1871 to 1875 the increase by birth in Germany was 39.9 per cent., but in 1891-95 this had sunk to 36.3 per cent., and in the year 1897 it went down to 36 per cent. The general average from 1881 to 1885 was 36.8 per cent., but is now 36 per cent. More noteworthy is the decrease in Austria, where in the course of twenty-five years it has dropped from 39.5 per cent. to 37.4. In Belgium the percentage in 1871 was still 32.1, but in 1897 only 29; and in France the shrinkage in the same period was from 25.5 to 22.4. Next to Norway the most favorable data are reported from Switzerland.

**It would Appear from Statistical Statements** in the *New Hampshire Sanitary Bulletin* for January (*Journal American Medical Association*) that the people in that State are becoming immune to consumption, or that the disease is in some way or other losing its virulence there.—*Med. Times*.

**Primary Pernicious Anaemia, Family Type, Treated with Bone Marrow.** By Dr. V. Caccini. The writer reports a number of cases of primary pernicious anaemia that occurred in the members of the same family, in which he used bone marrow, and formulates the following conclusions as to the value of this substance in severe anaemias: 1. Pernicious anaemia is essentially a myelogenous disease. 2. Its symptoms are due to a deficiency of marrow in organism. 3. It can be cured by the administration of red bone marrow.—*N. Y. Medical Journal*.

**A \$10,000 Fee.** Arthur Goebel, brother of the dead Governor and his devisee under the will, has placed a claim against the estate of Gov. Goebel for \$10,000 for Dr. McCormack's services. Gov. Goebel and Dr. McCormack had long been close friends and when Goebel was shot Dr. McCormack, who happened to be in Frankfort at the time, was one of the first physicians to come to his assistance. The wound was mortal, but knowing that if life could be prolonged a few days the Legislature would decide the contest, and that in the state of feeling resulting from the assassination Goebel would probably be declared Governor, Dr. McCormack took every step known to science to maintain life. Dr. McCormack refused to render any account for his services on the ground of personal friendship.

**Character of Modern Chinese.** The following by no means flattering estimate of the Chinese character is given by one who has lived in their country for years and should, therefore, be qualified to judge. He says: "The modern Chinaman we know is the most selfish of mankind, callous as an animal, with only a relic of conscience; disinclined to fight because he thinks of himself first, and utterly corrutable because money is to him the supreme protection; but nevertheless a strong man with a clear head for affairs and with a strong faith, though it is in his civilization and not in any creed. . . . He is the most accomplished liar in the world, but he does not love lying as a Hindoo does, as a pleasurable intellectual excitement, but lies exactly up to the point where, as his native shrewdness tells him, lying is convenient for his interests."—*Medical Record*.

**Strychnine in Arteriosclerosis.** This drug should be used with considerable caution when there are vascular changes predisposing to apoplexy, because of its well known effect in raising the blood pressure.—*Denver Med. Times.*

**Kafir Cure for Dysentery.** It is reported that several of the army surgeons have tried the Kafir cure for dysentery with marked success in some very bad cases. It consists of a decoction of the root of the pelargonium or geranium. There are upward of 150 different kinds of wild geranium in South Africa, and each seems equally efficacious in cutting short an attack of dysentery. The Kafirs and Zulas simply chew the geranium root, but a more elegant preparation is made by boiling the root in milk. One or two tablespoonfuls are given every two hours till all symptoms of dysentery have disappeared. It would be desirable to obtain the name of the species. Our native geraniums, while having a mild astringent action, are not very efficacious in dysentery.

**It is so Easy to be Wise after the Event.** The *Polyclinic* for August says that the late Sir George Burrows used to tell a good story of an old Duke of Portland, long ago dead. Sir George had been attending a lady in the Duke's household, but had never met his Grace. One morning a missive was given to Sir George, which ran: "The Duke of Portland begs to hand to Sir George Burrows a prescription for dropsy which has long been in his family, thinking that it may be of use in Mrs. —'s case." The reply was as follows: "Sir George Burrows begs to thank the Duke of Portland for the prescription he has so kindly sent; Mrs. — is, however, now well rid of her dropsy, but she still has organic disease of the heart, and if his Grace has a remedy which will cure her of that, Sir George will be thankful for the prescription."

In like tone, says the *Polyclinic*, it might have been quite fair had Lord Lansdowne thanked Sir W. Foster for the remedy (his own supervision) which he had suggested would, had it been duly adopted, have prevented the overcrowding of the Bloemfontein hospitals. That evil had now, however, ceased to exist, but there remained the possibility that in future wars the enemy might break bridges, destroy railway lines, and in various other ways make it difficult to send up medical supplies. If Sir Walter knew of a panacea against such contingencies Lord Lansdowne might have admitted that he would be glad to be informed of it.—*N. Y. Med. Jour.*



**Harmless Sleeping-Draught for Nervous Insomnia.** To a tumbler of sour curds and whey add a teaspoonful of carbonate of soda, or as much more as is required to make it alkaline. Sweeten it with sugar or treacle, and grate some nutmegs on the top. It may be taken cold, but is best hot.—*Indian Lancet*.

**Peroxide of Hydrogen as a Local Anesthetic.** Dr. H. E. Kendall, of Sydney, N. S., writes: "I have not seen anywhere peroxide of hydrogen spoken of as a local anesthetic, and as it has proved very satisfactory in my hands I venture to mention it in your paper. Injected under the epidermis it produces immediate and complete anesthesia of the whole skin. I have used it for over a year, in opening abscesses, cutting off redundant tissue in in-growing toe-nails, opening the pleural cavity, and in one case the abdominal cavity. I do not think any absorption takes place, as the intercellular inflation from the gas generated seems to produce such pressure that the skin cuts like frozen tissue."—*Med. Record*.

**The Injurious Effects of Improperly Constructed School Chairs.** Dr. J. Stone writes: The choice of the "Oblique" or of the "Vertical" script in handwriting seems to have much to do with the incorrect posture in writing. The ordinary type of lateral curvature is that of the writing position. When the oblique penmanship is practised, the head turns so that the eyes may follow the line of writing, the centre of gravity is altered, the left arm slips from the desk and is lowered, while the right is pushed forward and upward on to the desk. The vertical style of writing does not seem to possess this undesirable tendency to distort the spine. Aside from the method of writing, certain well-defined principles should be observed in the building of the school desk. The height of the seat should equal the knee height, the width of the seat should be slightly greater than the width across the buttocks, the depth of the seat should be about two-thirds the length of the thigh, the difference between the height of the desk and the height of the seat should correspond to the height of the elbows above the tuberosities when the arm is very slightly raised, as in writing. A properly constructed desk should conform to these requirements. The slant of the desk itself, and of the chair back, are other factors to be considered. These questions are of the utmost importance, in the opinion of the author, as only those children who are unquestionably strong can withstand the effects of improperly constructed desks.—*Boston Med. and Surg. Jour.*

**The Medical Complications of Gonorrhœa.** Dr. Samuel B. Ward says: Besides the genito-urinary organs in the male and the female, the eye, anus, rectum, and mouth, occasionally become affected with the poison. The nose is very rarely affected, and parotitis and mastitis are rare. The gonococcus may gain admission to the blood current and so may reach nearly every organ of the body, giving rise to local inflammation, and even to general septicæmic infection as shown by Thayer and Blumer in 1895. Pleurisy, pneumonia, endocarditis, pericarditis are named among diseases that have been found to be at times due to gonorrhœa.

**A Case of Fecal Tumor.** Dr. W. Poten (*Centralblatt für Gynacologie*) reports the case of a virgin, nineteen years of age, who presented a hard, irregular, and somewhat nodular, tumor of the abdomen which reached above the umbilicus and could be felt in the pelvis. The fundus uteri could not be definitely located nor could the appendages be felt. The diagnosis lay between ovarian cyst and myoma of the uterus. While the patient was in the ward awaiting the suggested operation, the tumor changed its appearance, its form and its consistency after repeated enemata which were administered for the obstinate constipation. A diagnosis of fæcal impaction was then made, and after the use of many high enemata and mineral waters, the tumor gradually disappeared.

**A Curious Conception.** A woman named Akroyd, says *The Barrister*, was tried before the Court of Queen's Bench in Dublin for refusing to produce a child which she had abducted. Some amusement was created in court when the prisoner was sentenced to six months, without hard labor, in Richmond prison, which is only for the incarceration of males. Carved in the stonework over the main entrance to the prison are the following words: "Cease to do evil, learn to do well." The commitment was the subject of the following lines:

In most earthly tribunals some harshness prevails,  
But the Court of Queen's Bench is both prudent and mild;  
It committed Miss A. to the prison for males,  
As the readiest mode for producing a child.  
How she'll do so surpasses conception to tell,  
Should she "cease to do evil and learn to do well;"  
And if in six months without labor confined,  
She produces a child, she'll astonish mankind.

—*Indian Lancet.*

**The Physician as a Speculator.** That the physician is a poor business man is of such general belief that he is regarded as legitimate prey by promoters of fake schemes, worthless inventions and the like. The *Philadelphia Medical Journal* is responsible for the statement that a well-known New York oculist, entering as a silent partner in a firm last January, put in \$200,000. Result, a total loss, the firm failing for \$500,000. Another specialist lost \$25,000, several times on Wall Street; he is now dealing real estate along the Jersey Coast. Some years ago a specialist lost two fortunes in patents and is now too old to make another. Moral: Do not go into a financial undertaking to which you cannot, in a measure at least, give your personal supervision, and do not allow another man or set of men handle your money for you, for in the majority of instances their principal business rule is an embodiment of the latter day philosophy to "do unto others as others would do unto you, only do it first."

**The Effects of Cocaine.** An apothecary of the West Indies undertook to experiment on himself to determine the effects of cocaine on the human system. In a contribution to the *N. Y. Med. Journal* he gives the following lively account of his experiences during the test:

"After the first quantities, say between five and ten grains were swallowed, I felt elated, full of life and vigor, cheerful, seeing everything in the rosiest of lights; my mind would clear up and things incomprehensible to me at other times would become plain and evident. I would be willing to and actually did undergo heavy physical and mental work which under normal conditions I could not possibly have accomplished. It is the most agreeable of sensations, because one feels perfectly and serenely happy. As the dose increased the symptoms would change gradually till the full amount being absorbed, the toxic symptoms appeared. I felt haunted, restless, morose, quarrelsome; had hallucinations of being persecuted and of impending evil; my heart would be pounding at a fearful rate so that I could actually hear its throbbing; the eyes got glassy, with a fixed staring look; the tongue was heavy and unable to move at will; a terrible and incessant hacking cough shook the frame; the mind was obfuscated; there was inability to eat, with no feeling of hunger, and there were insomnia and an insatiable craving for alcoholic stimulants. These were the most terrible of the many symptoms. Under ordinary circumstances I can stand no strong drinks, and yet, under the cocaine influence I drank daily a bottle of brandy during those hours, and when no other drinks were at hand I often actually drank pure alcohol, such was the craving for it; and probably it was due to the cocaine that I never got so intoxicated as the amount of liquor taken would justify one in believing."



**Treatment of Summer Diarrhea in Infants.** Dr. C. G. Kerley says (*Med. News*) the true nature of summer diarrhea is not appreciated by the rank and file of the profession. If we can bear in mind that in so-called "summer diarrhea" we have a disease due to virulent organisms, much will be accomplished.

The child is poisoned. Cholera infantum is due to direct infection. There is a tendency for summer diarrhea to get well if left to itself. The treatment is simple, consisting chiefly in elimination and diet. Irrigation is of value by means of a soft catheter, No. 14, English. The writer has discarded the white of egg in milk in favor of dextrinized barley. Opium must be used with great caution. The utmost cleanliness must be observed in preparing the infant's food.—*Med. Record*.

**Curability of Syphilis.** Tarnowsky (*Arch. Russes de Path.*) has published a report on a series of fifty cases of syphilis observed by himself, in most instances the appearance of the initial lesion in which complete cure appears to have taken place. The minimum period of observation is twenty years, the minimum time since the last syphilitic manifestation, sixteen years. All doubtful cases, presenting complications, such as aortitis, nephritis, etc., are eliminated. One man, sixty years of age, had a chancre in 1862 and some secondary symptoms, and has since then been free from symptoms. In the case of a man, seventy-nine years of age, fifty-five years have passed since he presented gummata of the face. In one case only the chancre had been the only sign of the disease; the other patients all showed secondary or tertiary symptoms. Of the 48 men and 2 women patients, 27 men and the two women married; out of 65 children, 56 exhibited no signs of hereditary syphilis. The patients belonged to the intellectual class and represented all varieties of professions. As they were all of robust health and all almost free from the hereditary taint, Tarnowsky concludes that these points are factors in a favorable prognosis. In respect to treatment, 20 used mercury from the time of the chancre, two were given iodide treatment from the first, and 27 received no mercury until gummata appeared. Treatment was in general less extended than as advised by Fournier. From his study of these cases, Tarnowsky concludes that syphilis is curable, and urges that patients be encouraged to believe this, while not depreciating its gravity, in order to gain the advantage of their physical good condition in promoting their physical recovery.—*Medical News*.

**Headaches.** A physician who has been experimenting to discover, if possible, a relation between headaches and the retention of uric acid, found experimentally that he could produce a headache in himself by adopting a diet of meat and cheese—foods which are highly nitrogenous and which in their burning up produce a great deal of uric acid. He found in himself an excessive excretion of uric acid during a headache, which perhaps means that a headache is a sign of nature's effort to relieve the system of a poison that would do worse than produce headaches were it permitted to remain. Such a headachy condition is comparable to the fevers which the human system often establishes for the purpose of ridding itself of disturbing impurities.—*Dietetic and Hygienic Gazette.*

**Syphilis of the Granddaughter.** Professor A. I. Pospeloff (*Vratch*): The question as to the hereditary transmission of syphilis to grandchildren and great-grandchildren has been the subject of investigation in the past without having been definitely solved, principally on account of the fact that the manifestations of hereditary syphilis are so proven that no definite diagnostic signs exist (Fournier). Syphilis of the second generation may be characterized by the same symptoms as that of the first, or it may be accompanied by a series of phenomena that are called parasymphilitic (Barthelemy). The manifestations of syphilis of grandchildren are unusually variable, and consist principally of a series of dystrophies, among which general atrophy plays a prominent part. In many cases there are no manifestations of the type of secondary or tertiary syphilis in these infants as we find them in the first generation. As a rule the atrophy begins in utero. The children are born prematurely and die at an early age, "of nothing," as the French say. The autopsies of these infants do not reveal anything characteristic of syphilis, in contrast to the findings in the bodies of hereditary syphilitics of the first generation. Of 83 autopsies on this latter class of infants the writer found that in the majority (61) there were more or less marked syphilitic lesions in the internal organs. In the second generation miscarriages are less frequent than in the first, and in those cases in which syphilitic grandchildren are born at term they may be perfectly well during infancy, but when they reach the age of from two to five years they become cachetic without any apparent cause. The diagnosis of syphilis in the second generation is very difficult, because the symptoms are so indefinite and the

history of parents and especially of grandparents cannot always be obtained. The author reports the history of a girl aged thirteen years. Her father never had syphilis, but stated that the child's grandfather was known to have had the disease and been treated for it. The patient was an anæmic girl whose size did not correspond to her age; the skeleton was ill developed and the whole appearance that of a girl of nine or ten years. She had a chronic rhinitis with the formation of thick brownish crusts and a deep ulcer of the hard palate. Her mother had twelve children, all of them born at term; two died during labor, of accidental causes (asphyxia, prolapse of the cord). The patient had suffered from coryza from earliest childhood. Both the patient and her father had Hutchinson's teeth. The child improved considerably under antisyphilitic treatment. The author believes that she may transmit syphilis to her children (in other words, hereditary syphilis in the third generation), and that syphilis in the second generation may be accompanied not only by dystrophies but also by gummatous processes, without necessarily being present in the parents.—*N. Y. Med. Jour.*

**Secondary Hemorrhage Following Use of Suprarenal.** The gratifying results which have attended the use of the suprarenal extract in intranasal surgery have made the introduction of this drug most rapid and its use, undoubtedly, a permanent one. After considerable experience, however, it has been found by many specialists that there is an important danger to be avoided in the matter of a secondary hemorrhage. F. E. Hopkins (*N. Y. Med. Jour.*, August 25, 1900) cites several cases in which he has had serious results from two to six hours after the use of this drug in nasal operations and also gives reports from many other authorities who have had similar experiences. Although the simple spraying of the nose with a suprarenal solution in cases of acute rhinitis has sometimes been followed by a secondary congestion even worse than the primary condition, this is a **rare exception** and the author believes that the serious secondary hemorrhages occur in those cases in which cocaine and the suprarenal extract have both been used. It would seem that the powerful stimulation to contraction of the swollen mucous membrane, induced by the suprarenal extract, while equal to retaining a grip on the dilated vessels for a time, is unable to prevent indefinitely the paralytic stage following the use of cocaine. He suggests therefore that the nasal fossæ should be carefully packed after each operation and, to be safe, an astringent should be employed.—*Med. News.*



**Amylen Hydrate in Diabetes Insipidus.** W. Niessen (*Therap. Monatshft.*, August, 1900) relates the case of a patient suffering from polyuria who was given amylen hydrate for insomnia with the unexpected result that the symptoms of his disease at once retrogressed. Following an extensive trial, the author concludes that small doses in many cases bring about a temporary improvement in the polyuria and polydipsia and, in a few, a permanent cure, thus making this drug, among the many others, worthy of consideration. The only drawbacks are the disagreeable taste and the insolubility of amylen hydrate which can be obviated by ordering it in capsules, to be followed by a glass of beer or wine.—*Med. News.*

**Some Things a Young Physician Must Learn.** The old adage, "Speech is silver, but silence is golden," must be borne daily—nay, hourly—in mind by the physician who wishes to succeed. We are, all of us, cognizant of the contempt in which a loquacious physician is held. Better far is it to be a little reserved, a little conservative, even to the point of exaggeration upon all subjects, private or general, than to be a medical magpie. Certainly, of things pertaining to his patients, their manner of life, domestic affairs, connubial felicities and infelicities, etc. The family physician, holding the position he does, naturally becomes quite well informed concerning these things, but his lips should be sealed in regard to them. Even his wife, if she be a woman nobly planned, will not wish to share his knowledge regarding such troubles. Usually, she has enough trials of her own to bear without this additional burden.

A physician must have many irons in the fire. Not alone must he be content to remain in his office, wait for patients to arrive, attend to their physical needs, visit those not able to visit him, etc., but to become well known and, eventually, famous. We have reference, of course, to ambitious physicians, for there are sluggards in the medical profession as well as elsewhere. He must have his lines out in several directions and go over them constantly, one after another, as a fisherman does his nets. It is not necessary to become a jack of all trades, but there are many different phases connected with his profession in which he can be greatly interested, all hinging upon one common pivot, the good of humanity, and in one or more he can surely gain renown if he labors faithfully and industriously, thus benefiting both himself and the human family.—*The Medical Summary.*

## Counter-Irritants.

## Chased by a Shadow.

A man was going home to his wife and family. It was growing dark. His road from the station was a lonely one; and he was getting along as fast as he could, when he suddenly suspected that a man was following him purposely. The faster he went, the faster the man went, until they came to a churchyard. "Now," he said to himself, "I'll find out if he's after me." And he entered the churchyard. The man followed him. Vague visions of revolvers, of sandbags, and loaded clubs grew upon him. He dodged round a grave, and his pursuer dodged after him. He made a detour of a splendid mausoleum. Still, the man was after him, around and around. At last, he turned and faced the fellow. "What do you want? What are you following me for?" "Well, sir, do you always go home like this? I'm going up to Mr. Fitzbrown's house with a parcel; and the porter at the station told me, if I'd follow you, I should find the place, as you live next door."—*Exchange*.

"The Chuzzletops beat the world in economy. When Chuzzletop gets a cold he doesn't get his prescription filled until his wife gets a cold, too."—*Exchange*.

## Seven and Six.

The London newspapers made a distinction between a simple notice of a death, for which they charged five shillings, and a brief obituary, for which they demanded seven and sixpence.

One day Doctor Thomas Hume, a grave satirical London doctor, called at the office of a morning journal, and silently placed upon the counter the announcement of the death of a friend, together with five shillings. The clerk glanced at the paper, tossed it to one side, and said gruffly, "Seven and six!"

"I have frequently," answered Hume, "had occasion to publish these simple notices, and I have never before been charged more than five shillings."

"Simple!" repeated the clerk, without looking up. "There's an added line, 'universally beloved and deeply regretted!' isn't there? Seven and six."

Hume produced the additional half-crown, and laid it deliberately by the others, observing in his most solemn tone, "Congratulate yourself, sir, that this is an expense which your executors will never be put to."—*Youth's Companion*.

### The Bacillus Agnostic.

(AFTER LONGFELLOW—ABOUT NINETEEN YEARS.)

In from his rural dominion,  
 Fresh from his rustic location,  
 Came the bacillus agnostic,  
 Rank disbeliever in microbes.  
 Talked he right bold to the doctors—  
 Those who believe in the ptomaines—  
 Thus spake Reub, sore on such folly:  
 "Long years ago in the country  
 Had we a place called a schoolhouse;  
 Always without ventilation,  
 Ever without any safeguard  
 'Gainst the onslaught of disease.  
 Never an oven for pencils,  
 Never a book fumigator,  
 Never a bit of precaution  
 Other than such as beasts have.  
 (Some asafetida, surely,  
 Eke, some small baglets of sulphur.)  
 Drank all we brats from one tincup,  
 Aye, from one bucket we guzzled;  
 Some even poured back their leavings!  
 Sometimes a slate that was borrowed,  
 Bearing nine kinds of dried moisture,  
 Had to be cleansed before using—  
 Used we our tongues for the cleansing.  
 Yet was there none of us ailing;  
 Ne'er had we heard of the microbe."  
 Thus spake the bacillus agnostic,  
 Rank disbeliever in ptomaines.  
 Silence from all of the doctors.

—*Indianapolis Journal.*

Judge Byles was one day trying a man for stealing, when a medical witness was called, who stated that in his opinion the prisoner was suffering from kleptomania. "And your lordship, of course, knows what that is." "Yes," said Byles, quietly, "it is a disease which I am sent here to cure."—*Exchange.*

The late King Humbert recently visited an Italian hospital and left a sum of money with the directors, so that the patients might each have some additional delicacy in honor of the event. One of the sick men hearing of this complained that his dinner had been no better than usual. The nurse explained to him: "My good fellow, the state of your health doesn't permit of any change in your diet, but the doctor had ordered you a dozen leeches, and, as a treat, we are going to apply eighteen."



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